NAADAC

ADDICTION TREATMENT IN MILITARY & VETERAN CULTURE
PART FIVE

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>> SAMSON TEKLEMARIAM: Hello, everyone, and welcome to Part 5 of 6 on this Specialty Training Series on military and Veteran culture. Today's topic is Identifying Presenting Concerns: Assessments competencies for Service Members, Veterans, and their Families. My name is Samson Teklemariam and I'm the director of training and professional development for NAADAC, Association for Addiction Professionals. I'll be the organizer for this session. And this online training is produced by NAADAC, the Association for Addiction Professionals and closed-captioning is provided by CaptionAccess.

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Now, let me tell you about this presenter. Duane K.L. France is a retired Army non-commissioned officer, a combat Veteran, and clinical mental health counselor practicing in Colorado Springs, Colorado. He’s the Director of Veteran services of family care service, a private outpatient mental health clinic specializing in supporting wellness and Service members, Veterans and their families. He is also the Executive Director of the Colorado Veterans Health and Wellness Agency, a 501 (c)(3) non-profit affiliated with the Family Care Center. Duane is a member of the public policy and legislation committee for the American Counseling Association and the Military and Government Counseling Association. He is a member of the inaugural class of the George W. Bush institute Veteran leadership program and is active in legislative and public advocacy for both the military population and the counseling profession.

In addition to his clinical work, he also writes and speaks about Veteran mental health on his blog and podcast, Headspace and Timing. Which you can find at www.veteranmentalhealth.com. NAADAC is delighted to continue this series presented by this accomplished trainer. So, Duane, if you're ready, I will hand this over to you.

>> DUANE K. L. FRANCE: Thank you, Samson and thank you, everyone, for joining us for this 5th in the series of 6 webinars on competency in addressing mental health in the military affiliated population. The first couple of slides here, I'd like to provide a review of the comprehensive Veteran mental health model that we discussed in the first couple of webinars and then the competencies that we're currently discussing in these last four.

So to briefly go through this, these are number of different types of conditions that Veterans face when addressing mental health in their post-military life. So many people are, obviously, where post-traumatic distress disorder, the impact, especially among combat Veterans but necessarily just combat Veterans. Traumatic brain injury is also a significant concern as many of the attendees and NAADAC professionals know addiction and co-occurring disorders in the military affiliated population is significant. And then of course the emotion dysregulation, which is typically for Veterans, in my experience, anger, anxiety, and depression. There is obviously an emotional component to PTSD, which is complicated by TBI. But there are things like, you know, toxic leader and frustrated – frustrated types of career issues that lead to different types of emotion dysregulation.

Also a lot of Veterans struggle with purpose and meaning, how they find purpose and meaning in their post-military life that was as significant as it was when they were in the military. Moral injury emerging as a construct in special the last 30 or 40 years to complement PTSD, but also as a separate condition from PTSD. Needs fulfillment, how do Veterans and their families fulfill their needs in post-military life. Of course, if we're thinking about Maslow's hierarchy of needs, those basic needs as far as housing and safety, but also transition how to meet the higher level needs, the aesthetic needs, and the social needs where they're no longer able to fulfill those needs in the way they did in

the military. And then, finally, relationships. Our relationships, this impacts relationships.

So if we are addressing Veteran mental health or mental health in the military affiliated population, we have to consider all of these different areas as critical and where a client is in each of these areas. As I've mentioned in these last four webinars, we're talking about the core clinical competencies for treating Service members, Veterans, and their families. These are the list of the overall competencies. You'll see on the bottom of the slide, there is a link where you can go to Veteranmentalhealth.com/NAADAC5 for the fifth webinar. I've listed the entire competencies there. We are only covering four with the overview of the competency, and then three subcompetencies in these last three webinars. But as you can see there's a number of different ones. And there are subcompetencies in each of these.

We discussed military culture in webinar 4. This webinar we're going to be addressing assessment of presenting concerns. And the last webinar No. 6 will be covering treatment. So this webinar specifically on the assessment of presenting concerns is one that represents common areas of clinical concerns that Service members frequently present to mental health services to address. This, while I will be talking about some specific assessments during this presentation, this is more about what to look for. Some common things to look for when we're addressing military populations.

Next we will turn it over to Samson for Polling Question 1.

>> SAMSON TEKLEMARIAM: Thanks, Duane. And we'll go ahead and launch this poll. You'll see it on your screen in just a moment. Service members and Veterans are more likely to apply stigma against seeking help to other members of the military population. You will see five answer options pop up on your screen. Go ahead and answer this question. We'll give you about 20 seconds, and as you're answering this question, hopefully you have a sticky note or something nearby. Just a reminder, in order to access this CE quiz, please view the entire training and listen for the password. The password is revealed in three separate sections. As a reminder, when you go into

the online CE quiz, the password is just one word all lowercase. Here, I'm going to share with you the first part of your password.

The first part is [redacted] Again, [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance). And, of course, if you have any questions for our presenter, please make sure to send them into the questions box and the presenter will answer them in the order which it is received during our live Q&A. It looks like almost 70% of you have responded. Oh, there it is. Just jumped up to 79, 80%. So I'm going to go ahead and close the poll and share the results. And I'll turn this back over to Duane.

>> DUANE K. L. FRANCE: So, it looks like a number of you agree that Service members and Veterans are more likely to apply stigma against seeking help to other members of the military population. This is actually counterintuitive in that in my experience and some of the research that I'll discuss here in a minute shows that they are more likely to apply stigma to themselves rather than to their fellow Service members. They actually want the other Veterans to get help. My brother and sister needs the help more than I do. But they very much apply stigma more internally to themselves than they do to others. So this is something that you'll hear often and we'll talk about in the upcoming slides.

Some of this is when we – I often hear this with Veterans on coming in to treatment in that I don't want to take up too much of your time. I don't want to, you know, other people need more than need this more than I do. And I'm not as bad as others. And, so, as I often say, a Veteran doesn't need much reason to avoid mental health treatment. But applying this stigma to themselves is usually one of the biggest.

So one of the first subcompetencies to discuss when we're talking about assessment of presenting concerns is that we need to understand that military-connected clients are often concerned that they will experience stigmatization, which creates barriers to seeking mental health services. A stigma is defined as a mark of disgrace associated with a particular circumstance, equality, or person. Looking at seeking mental health services as disgraceful and shameful decreases help-seeking behavior.

There is a perceived public stigma that someone's perceptions regarding the extent to which the public holds negative stereotypes about villains, or about Veterans. Usually, I define this as the villain. The crazy combat Vet, the John Rambo that's going to take over the town. The victim, the poor broken-winged bird, you know, let me help you in receiving handouts. And then the hero, right? You know, the mythic warrior striding across the battlefield saving the planet.

And, so, these are some of the stereotypes that I personally, as a Veteran, have experienced and other Veterans have experienced. And while we're none of these things, and maybe sometimes all of us are all of these things. But these are some of the public perceptions that some Veterans will have that they will avoid seeking treatment, for example, in order to avoid a bolstering the victim mindset. Or they don't want to experience the, you know, the hero worship that might sometimes happen.

Service members, Veterans, and their families clients may not want to seek help for mental health concerns in order to avoid discrimination from others or perceive judgment. And this is talking about how we apply stigma differently to themselves versus applying stigma to others. In this study conducted in 2015, all of these resources are linked at the Veteranmentalhealth.com/NAADAC5. 50% of Veterans, they said they thought other Veterans would see themselves, see the Veteran as weak for seeking help. But only 12% of those same Veterans said they would view other Veterans as weak. This is one of the issues that, again, we want other Veterans to get help but seeking help for ourselves we assume the stigma is there.

And then if Veterans don't talk about it, then that just perpetuates the issue. A RAM study has identified a number of strategies that should reduce or could reduce stigma in the military population by increasing treatment seeking behavior. Such as decreasing the isolating impact of stigma, letting Veterans know that they're not alone. Influencing cultural change. This should and likely anecdotally is starting to happen in the military. But just in the Veteran population, there's cultural change against treatment seeking behavior. Peer support, especially, in this particular population has shown to be very, very beneficial. Not just for treatment support, but also increasing

behavior. You know, hey, I'm seeking treatment and it's working really well, so you should do the same thing.

Changing perceptions about the effectiveness of mental health care. This is one of my experiences is that if a Veteran has a bad experience with a therapist, for example, they globalize that to all treatment, right? I had this bad experience, so all therapy is bad. But when they have a good experience, it is very localized. I had a good experience with this therapist, so this therapist is good. And you should only go see this therapist. And, so, really, it's how do we change that in that we localize Veteran's bad experience with a therapist, this one experience with therapist was bad, and we generalize this from the good experiences in that I had a good experience with this therapist, and, so, overall, mental health care is effective.

And then, finally, reducing barriers to care. We've addressed this in some of the other webinars. But things like, you know, payment or access to care is for rural Veterans, or bad paper Veterans. Anything, again, the idea of a Veteran doesn't need much of a reason to avoid therapy, the more barriers there are, the more that they will avoid it.

Another one of the competencies for assessment of presenting concerns we need to be aware of, and we were talking about this in the earlier in the slide when it came to the comprehensive Veteran mental health model is traumatic brain injury. So clinicians need to recognize that the prevalence of traumatic brain injury and head injuries during the military service and needs to be aware that the TBIs are associated with higher rates of other mental health and physical symptoms. I often describe, for example, those areas in the comprehensive Veteran mental health model is cracks in the foundation, right? The more cracks we have in the foundation, the hard it is or the worse it is for the house that the foundation's built on. So if we're experiencing PTSD, emotion regulation, and moral injury, and lack of purpose and meaning and, so, on, traumatic brain injury is a crack that sort of cuts across all of the other cracks and might and often does make them worse and exacerbates these symptoms.

Even in peace time, military personnel have a higher rate of traumatic brain injury than non-Service members. As I've mentioned before, I had a concussion that

was sort of welcomed to Fort Bragg in the 82 Airborne Division. Not through hazing, but through my jump in particular in I think the fall of '98. It wasn't in combat. It was in a training accident. I have had Veterans who experienced severe traumatic brain injury not from combat but from, you know, a motor pool accident, a vehicle falling from the vehicle or things like that. And so the multiple being an inherently dangerous population, military have a higher rate of traumatic brain injury than others.

Incidents of TBI do increase during wartime. And the source of the injury reflects the wounding patterns of combat with closed brain injury being most prevalent but penetrating brain injury increasing. And, so, if we're talking about Veterans, we need to understand the difference between a closed brain injury often called a concussion. Then the penetrating brain injury, which is, you know, shrapnel or exposed skull. Or things that are actually penetrating into the skull.

Also the difference between a focal and a diffused traumatic brain injury. Declining more facilitate rates in recent conflicts due to advances in equipment and medical response result in individuals who survive with head and neck injuries. In Vietnam, likely there would have been a lot more traumatic brain injury, but the mortality rate was higher due to the lack of advances and equipment. But equipment increased equipment, increased helmets, and vehicle designs in such a way to avoid blast, they do reduce fatality, but do increase catastrophically injured Veterans to include traumatic brain injury.

Blast attacks due to mortar fire and improvised explosive devices have increased in current conflicts. In 2006, nearly two-third of combat zone evacuations were due to blast injuries, and 88% of injuries seen at theater aid stations were due to blast injuries. Again, the difference between a concussion, a coup counter coup focal concussion when someone, you know, hits their neck snaps back, and then the brain sloshes around. As opposed to a diffused brain injury, we're starting to see with a lot of blast injuries that cause injury across the brain, things like axonal shearing and, so, the access sons in the neurons of the brain are sheared, which if you know neurology will require greater electrical if chemical energy to be able to jump those gaps.

And, so, this traumatic brain injury again is one of those issues that if you are treating a Veteran, really understanding have they ever been in a blast? Have they ever, you know, lost consciousness? How long have they lost consciousness? And, so, some of these things are one of the issues we have to pay attention to when assessing Veterans.

And think about TBI results from both blunt force trauma and blast over pressure resulting in both focal and diffused brain injuries as I've just discussed. 82.5 of clinicians diagnosed TBI across deployed and non-deployed Service members have been classified as mild TBI or concussion. Again, this is a classification that many Veterans also really maybe push against. Mild does not describe the severity of the symptom. The mild describes essentially the length of time that one has lost consciousness after the blast or after the concussion. And, so, you know, and I don't have the exact timeframe in front of me, but say mild may be, you know, less than a minute. Moderate may be, you know, several minutes up to 10 or 15. But if someone has lost consciousness due to a blast for a significant period of time, that's considered a severe traumatic brain injury. Again, you can have severe, severe symptoms with a mild traumatic brain injury. So mild really classifies the type of injury rather than severity of symptoms.

Before June 2010, routine TBI screenings were not implemented in Iraq or Afghanistan, before that, many injuries were not immediately reported. And, so, if you have a Veteran who served in the beginning of the Iraq war during the invasion of Afghanistan, or even during the surge, and either of them in 2006 to about 2008 in Iraq, and then 2009 in Afghanistan, there may have been under reported traumatic brain injury and the Veteran may not even be aware that it's an issue for themselves.

A concussive TBI reported more depression and PTSD symptoms than control groups with more severity of both occurring before widespread TBI screening in 2010. The severity of PTSD and depression appear to be strongly linked to overall outcomes after concussive TBI. Causality isn't able to be determined, but it's likely that PTSD, depression, and TBI work synergistically to worsen outcomes. So here, we're looking at

its not just additive. It's exponential. So the PTSD, the depression, the traumatic brain injury work together to worsen the symptoms.

Another one that is obviously one of the big two that we're talking about when it comes to mental health with Veterans is post-traumatic distress disorder. We need to be aware that the number of Veterans seeking and receiving treatment for PTSD continues to increase in congruence with continued military missions.

A colleague yesterday, I was at an event, and he mentioned that the Global War on Terror, so the war on Iraq and Afghanistan is old enough to vote. So we are 18 years into these two conflicts. This is the longest sustained conflict in U.S. history. This is the first multi-generational conflict that my colleague yesterday, as he was talking, his son is currently deployed to the same area of Afghanistan that he was deployed to when his son was a toddler. So this is some of the issues where we're first dealing with the first multi-generational conflict. We do have multi-generational combat Veterans. My grandfather was in World War II. My father was in Vietnam with his brothers. I of course and my younger brother are Iraq and Afghanistan Veterans. But this is a first time where we had seen a cross-generational conflict. And we are actually in the third generation of and approaching the fourth generation of this conflict.

Psychological response to combat has been referred to a number of times or number of different conditions. Shell shock, war neuroses, post Vietnam syndrome, and, finally, PTSD in the DSM-3. There are differing prevalence rates, but about 13.8% of Veterans returning from Iraq and Afghanistan meet the diagnostic criteria for PTSD.

So this is, of course, statistically significant, but it's also not the overwhelming majority that many people assume. I actually had a colleague one time who asked me how many deployments I was on, and I told her I had five. And she said of course you have PTSD. Without even asking me about the hardships of those deployments or really even any symptoms, in her mind, the fact that I just had five deployments automatically meant that I had PTSD, which was not necessarily the case.

Male Veterans of current and recent conflicts are four times more likely to develop PTSD than a male civilian. So, of course PTSD is not just a military-related

condition. You can get PTSD from vehicle accidents, from assault and sexual assault, of course, natural disasters and often unknown, but also very prevalent source of PTSD. But current and recent conflict Veterans are four times more likely to develop PTSD than male civilian.

And then the response to trauma is highly individualized, Service members exposed to the same trauma at the same time do not always develop PTSD symptoms. Some of this is assumed to be or could be part of it is that we believe adverse childhood experiences play into susceptibility of trauma later on in life. It could be natural resilience versus developed resilience. But this is one of the things that an individual can be in a fire fight with they are fellow Service member. One can develop severe PTSD and another cannot. So it's one of these issues that it's highly, highly individualized.

A meta-analysis of 32 articles based on observational studies about PTSD after combat identified there are 18 significant predictors of PTSD among Service member is Veterans. And, so, this is one of the challenges with PTSD. Its not just the individual has been exposed to combat, so, therefore, it's not a one-to-one, therefore they must have PTSD. There are number of different factors and different levels. Some of the risk factors for the development of PTSD include gender. Females were more likely to experience PTSD following combat. Sociodemographic, race and education were risk factors predicting development of PTSD. And enlisted Service members were more likely to develop PTSD than officers. Of course this might be the fact that there are more enlisted Service members than there are officers in the military. And, so, just the fact that more, the sheer numbers were higher that enlisted Service members were more likely to be exposed to traumatic events.

The branch of service, arm Service members were more likely to report symptoms of PTSD. They are the largest force, again, and likely had the most traumatic exposure. And then the number and cumulative lengths of deployments. Service members with a greater number of deployments, and longer cumulative lengths of deployment were at greater risk for developing PTSD.

With that being said, there are risk factors for developing PTSD such as if it is a male young individual with substance use and previous psychological diagnosis. Those four factors have been shown to increase the likelihood that one would develop PTSD. And, so, it's one of those things that if they are exposed to trauma, then they likely could experience post-traumatic distress disorder.

Next up, we will have Polling Question 2. So I'll turn it over to Samson.

>> SAMSON TEKLEMARIAM: Thanks, Duane. Everyone, you will see this question pop up on your screen in just a moment. It asks combat exposure increases the risk of members of the military population to develop comorbid psychological conditions. You'll see five answer options there. It looks like a quarter of have already answered that's popped up on the screen. I'll leave it up for another 15 seconds or so. And as a reminder, in order to access this CE quiz, please view the entire training and listen for the password. The password is revealed in three separate sections.

When you go into the online CE quiz, you will enter it all as one word, all lowercase. Here, I'm going to share with you the second part of your password. The second part is [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

Again, [redacted]

And, of course, if you have any questions for our presenter, please make sure to send them into the questions box. And our presenter will answer them in the order in which they are received during our live Q&A. Before I turn this back over to Duane, let me go ahead and close this poll. It looks like a little over 90%, almost everyone was able to answer. We'll share the results and turn this back over to Duane.

>> DUANE K. L. FRANCE: Thank you, Samson. Again, this is much more intuitive and likely based on our experiences in working with Service members, Veterans, and their families. But combat exposure does, in fact, increase the risk of comorbid psychological conditions.

Talking just about comorbid substance use disorders, but also situations like depression, anxiety, inability to regulate anger, marital issues, and things like that. So,

there is a significant correlation. When looking at the assessment of presenting concerns, we need to be aware that combat exposure does increase the co-occurrence concerns such as substance use disorder and suicidality. Comorbidity of PTSD and alcohol use disorder has been an increasing the prevalent among military Service members. Just over 30.9% of Vietnam era Veterans met criteria for PTSD after transitioning to most military life with 70% of those also meeting criteria for alcohol use disorder.

One of my mentors, as I first started getting into the career field, who was a substance use counselor and a licensed professional counselor for the Army, again, said it's about 80% of individuals who are presenting with psychological concerns, depression, anxiety, PTSD. 80% of those also had a co-occurring substance use disorder.

Co-occurring PTSD and alcohol use disorder has contributed to more significant decreases in health functioning and greater difficulties and re-adjusting to non-military life. Comparisons between military and civilian populations, heavy drinking behavior was greater among military personnel, especially, those deployed to combat zones.

Of course, that doesn't mean that we're dinking during the combat zones or while we were in the combat zones. It was that individuals who had been deployed to combat zones had increased heavy drinking behavior.

25% of post 9/11 Veterans reported alcohol misuse after deployment, with experience of direct threat of death and injury while deployed was predictive of alcohol-related problems. of course as we know as clinicians that were reported is significant likely does not mean that all of the number of Veterans who increased their alcohol misuse. And in earlier webinars, we had discussed about how the military is a drinking culture. Drinking is part of it. But often as I work with Veterans, we talk about the reason for drinking, why the drinking occurred. Perhaps before deployment, the drinking was, you know, to relax or enjoy, or hang out with the guys and gals. Or maybe it was to celebrate or it was just something that you did.

Whereas, after deployments, if the reasons for the drinking behavior changed, thing like I was using it to get to sleep, or to stop the nightmares, or to numb physical or psychological pain, the change in the reason for alcohol misuse is usually significant and indicates things occurred during the deployment that caused distress for the Veteran.

Some studies have found a correlation between combat exposure and suicide while others have found no association. The earlier risk factors that I had mentioned for PTSD, I need to correct myself. I actually meant that those were the risk factors for suicide. I was caught up in the PTSD role there. But those risk factors of being male with a substance use disorder, and a previous mental health condition, those were risk factors for suicide and combat exposure didn't have that. One of the things of how do we really get our hands around this is the fact that combat exposure and suicide sometimes do have a link in some studies, and others hear none.

A large-scale Army study assessing risk and resilience in Service members, an increased risk among current or previous employed Service members, but upward trend of suicide among never deployed Service members which indicates that combat exposure is not an exclusive cause. So, again, jumping to conclusions of, well, you must be – or you would deployed five times, so you must have experienced suicidal ideation, or you may be at-risk for suicide. Whereas, somebody who has zero deployments, you're at low-risk for suicide. That's not necessarily the case.

So we really have to be careful in understanding or assessing suicide and not base it just on combat exposure. Morbid thoughts and suicidal ideation, MTSI, did increase with exposure to trauma. Especially, killing in combat as opposed to just witnessing death or experiencing a traumatic event. And, so, the psychological pressures of the killing in combat has been seen to increase these morbid thoughts and suicidal ideations.

And then increased MTSI was also correlated with other suicide vulnerability factors, such as alcohol dependence and readjustment stress. So this, again, we're really getting into the moral injury piece. We're brought up not to, you know, "thou shalt not kill" or on moral codes when we are growing up that we received in various ways.

Sort of told us that killing is bad. And that's absolutely necessary in a nation of rules and laws that we currently have. And then Service members are indoctrinated and assimilated into a different culture and into the military where killing happens, but there is still some of that psychological dissonance. And for some individuals, that psychological dissonance has increased these morbid thoughts and suicidal ideations.

Continuing to talk about the alcohol being the most prevalent substance Veterans misuse and frequently co-occurs with other mental health concerns and suicidality. Estimates of alcohol misuse among post 9/11 Veterans range from 12% to 40%, with young Caucasian unmarried Service members with mental health problems and more combat experiences having an increased risk for alcohol misuse. So in this instance, combat exposure does indicate that there would be a likely higher use of increased alcohol misuse. But, again, this is very cyclical, because increase suicidal risk comes with increased alcohol misuse and substance misuse.

A majority of post 9/11 Service members with mental health and/or substance use disorders have not received treatment. And, so, in a study in early 2018 from the National Academy of Sciences, looking at the VA's mental health, less than 50% of Veterans who screen positive on a measure of assessment for concerns, a number of people like depression, anxiety, and substance abuse, over 50% received screen positive, but only about 30% of them actually recognized they had a problem. And only 16% of that 30% actually received treatment for it. And, so, this is one of the issues, and it goes back to the self-imposed stigma of first awareness that there's a problem, and then once we're aware that there's a problem, what action steps are we taking to address that problem?

Veterans do endorse alcohol problems at rate similar to other mental health concerns. They are also referred to alcohol treatment at lower rates. So this is one of the things when it comes to after the military when someone is experiencing mental health concerns, maybe they're going to therapy for PTSD. Are they referred to an alcohol treatment or a substance use disorder specifically to address their treatment of their substance use disorder. That doesn't always occur. So if someone is working with the Veteran, for example, here in Colorado Springs, we have a very, very good

substance use disorder clinic in our local community-based outreach clinic for the Department of Veterans Affairs. In my experience, and I've worked very closely with those colleagues for a number of years.

If a Veteran's primary concern is their substance use, and that's a barrier for getting to some of the other thing, then absolutely, I refer them to there if they're eligible. So it's critical, and in my experience, that anyone working with Veterans needs to have some basis of understanding around substance use and know where the limits of their practice are so they can get that Veteran to the correct treatment.

Of course, we know untreated alcohol problems can lead to exacerbation of mental health symptoms, problems in daily functioning, and interpersonal difficulties. Alcohol use is a significant risk factor for suicidal behaviors as we've mentioned. Acute alcohol use is associated with suicidal behavior with many consideration alcohol use as a causal factor. Again, in my experience, if we look at back the Comprehensive Veteran Mental Health Model, if a Veteran has their substance use under control and they have some stable relationships in their lives, then they can sort of manage the traumatic brain injury and the PTSD and so on. It's when the substance use is not under control and they don't have stable and supportive relationships that those two things do seem to be an exacerbating factor. But alcohol use, someone may not engage in suicidal behavior when they are sober, for example, but more likely to do so when they are not sober.

In a review of Veteran suicides, nearly 1/3 of young Veterans who died by suicide had a blood alcohol content greater than .08. So illegally intoxicated. This is one thing that, again, here in El Paso County and Colorado Springs, Colorado, we are conducting some assessments on the suicide, Veteran suicides in our community. And one of the things that is looked at is whether alcohol, marijuana, or opioids were present in the individual's system whenever they died by suicide. And a significant number of them are.

Alcohol use disorders were elevated in young and middle-aged Veterans who died by suicide compared to older Veterans. And then evidence of alcohol dependence appeared more prevalent in middle-aged Veterans who died by suicide compared to young and elderly Veterans who died by suicide.

So, alcohol use disorder versus alcohol dependence, obviously, in here it's talking about Vietnam era Veterans who are experiencing more alcohol dependence. We're not seeing as much of the chronic biological dependence on alcohol in suicides in the younger generation. However, like everything else, if we don't get a handle on it, then those younger generation Veterans will continue to emerge into this statistic with increasing alcohol dependence.

So now I will pause and I will hand it over to Samson for some questions.

>> SAMSON TEKLEMARIAM: Thanks, Duane. So, we're just collecting some of these questions and trying to figure out which one to ask first. So I'll give you three for this time. The first one is when you talked about stigma and Veteran culture, are we adding to the stigma if we automatically screen each Veteran for PTSD? Is that overall assumptive or targeted if necessary?

>> DUANE K. L. FRANCE: No, that's a good question. I don't think it would add to the stigma. I mean, obviously, if the Veteran has gotten to us, then there is some type of concern. If I go to the doctor's office with a runny nose, there's a symptom there. And I expect the doctor to tell me whether it's the flu or whether it's allergies, right? So I don't think at this point assessing and looking to, we're going rule out these things. We're going to rule out PTSD. We're going to rule out depression. Or we're going to identify it. So I think when it comes to clinical, it's very critical to be able to understand that. With that being said, one thing to be aware of is, especially, again in my experience current era Veterans are very, very assessment sophisticated, let's say. Every time we came out of a deployment, we were asked all of these questions. And Veterans are very, very sophisticated to know which questions to answer in which way in order to, sometimes fake bad, sometimes fake good. But to really sort of not exactly provide the correct assessment.

And as my friend Samson and I were talking about this before the webinar started, the key to assessment is ensuring there is trust and rapport between the clinician so that when you do the assessment, you can say, or you can even address that, you know, this isn't to increase the stigma, but this is really to figure out what's

going on. This is a diagnostic test sort in the same way we would hook up your vehicle to a diagnostic machine to determine why the check engine light is on.

So I think it's a really good question. And it's very thoughtful. But I don't know that it would increase stigma.

>> SAMSON TEKLEMARIAM: Thank you, Duane. Another question is can you define again mild for TBI? What's considered mild versus severe TBI?

>> DUANE K. L. FRANCE: Yes. When we're talking about mild and severe traumatic brain injury, it is based on the amount of time that someone has lost consciousness after the injury. So, again, I didn't, and, of course, I mentioned it and I don't have the statistic here in front of me, which I will of course include in the printed or the follow-up questions.

But, really, a mild TBI is a short period of loss of consciousness. A moderate traumatic brain injury is sort of in the middle. But then a severe TBI is a significant amount of the loss of consciousness. It doesn't include the symptoms like I said. So a mild traumatic brain injury, and I mentioned getting my bell running. And I lost consciousness. I imagine probably about 15 seconds from a very, very hard landing from a parachute jump out of an airplane, which I loved, and, obviously, is a little maybe harmful to our physical bodies. But I lost consciousness for about 15 seconds. I was able to, you know, finish out the day. Drove home. I laid down in the living room floor and I slept for 18 hours. No good. I woke up Sunday afternoon to my wife, then my fiancé, standing over me with her arms crossed saying we're going to the doctor. I went to the doctor, and I was diagnosed with a concussion at this time. And then it was a concussion. Now it would be classified as a mild TBI. But I don't have or I didn't develop any long-term symptoms. And I'm not classified to have a sustained traumatic brain injury.

However, if I were to lose consciousness for a significant period of time, and I could have identified as a moderate or severe traumatic brain injury. So I will definitely get the actual timeframes. Just a little bit of research on the Google scholar like that will tell us what the actual timeframes are. But it's really just a short period of time. A

moderate period of time of loss of consciousness. And then an extended period of time of loss of consciousness.

>> SAMSON TEKLEMARIAM: Thanks, Duane. And we'll do one more and then I'll turn this back over to you. This is a long one that after months of working with the Service member who was referred because of a substance use disorder diagnosis and PTSD, we spent all this time discussing PTSD as trauma related to combat. But recently I learned from joining a local Vet group that my client was a victim of military sexual trauma. I feel like we've lost months of work, and he wasn't happy when this came out in the group session with me being present.

>> DUANE K. L. FRANCE: Question. So, yes, that is an absolutely common situation. I have actually worked with I'd say 5 or 6 Veterans with military sexual trauma. We'll actually get into that a little later in the webinar, because that is a critical part of it. But, regime, it goes back to what I was referring to as far as coming in with a symptom and was it, you know, I expect the doctor to tell me if my running nose is the flu or the allergies because we're going to treat them differently.

Depending on the Veteran's comfortable ability, or even sometimes whether the Veteran really actually realized whether military sexual trauma had occurred, that could be the source of it. Something not as – it was a very difficult situation. I'm certain for both you and the Veteran it's frustrating for both of you as well. But I had an experience with a Vietnam Veteran. We were discussing these aspects of the Comprehensive Veteran Mental Health Model. And we went through and he had been treated for the last 50 years, he thought it was, everybody said it's all PTSD. It's all PTSD.

Well, as we're going through this, and we're going through the different assessments, it turns out that his interpersonal relationships, some type of relationship or interpersonal breakdown preceded every single suicide attempt he had over the last 30 years. So mother passing away. Marriage breaking up. Even rejection or perceived rejection from someone at the VA. And, so, this is essentially people had been aiming at the wrong target. He had been aiming at the wrong target trying to address this. Where we still talk much, much more about his interpersonal relationships, how he sees himself, his self-confidence versus how others perceive him. And, so, it is very critical

to understand that it's not always going to be the first thing. I'm not saying obviously that you did any wrong. Because this is as it was presented. But you identify the fact that many Veterans may hide or not each be aware of the fact of the significance. To put a little bit more on this and we'll bring it up a little bit later. Many Veterans, I have a Navy Veteran right now who wasn't aware that a sexual assault as a child had exacerbated. He had PTSD before he enlisted in the military. And incidents that occurred in the military exacerbated that.

So some of it is lack of awareness on the Veteran's part and some of it is a, perhaps not exploring as deeply. I don't know that I always ask if there had been incidents of military sexual trauma. But I do try to pay attention to my Veterans where some of these things. Usually, in my experience, they will crop up in challenges with relationships or situations like that which will lead down a path to explore. I would say great question. Unfortunate situation, and thank you for sharing that with us. And we're going to hand this over to Samson for Polling Question 3.

>> SAMSON TEKLEMARIAM: Thanks, Duane. Everyone, the polling question is popping up on your screen now. It asks military Service members likely have a greater amount of adverse childhood experiences than the general population. You'll see 5 options from strongly agree to strongly disagree. We'll give you just about 10 more seconds to vote. It looks like a little over quarter of you have voted.

All right. Perfect. So about 70% have voted. Thank you for participating and interacting with this poll. We'll go ahead and close to the poll and share the results. And I'll turn this back over to Duane.

>> DUANE K. L. FRANCE: Thank you. So this is one that obviously, if we have had experiences with adverse childhood experiences in general population and maybe less so in the military, this is one of those sort of nebulous questions. In my experience, the military is as much as running away from something as it is running towards something, not just for the Service member, but also for the young Service member's spouse. I would say a significant number of the clients I see do have, if we're looking at the 10 adverse childhood experiences factors, a significant number of them, including abuse, physical, psychological, or sexual, injustice involvement in the home, substance

abuse in the home. And I've had a number of elite members of the military such as Special Forces and SEALs that in a description of a buddy of mine they have really, really messed up childhoods.

And, so, it is one thing I often, not that we go into Freudian cycle analysis, but understanding what some of the challenges were with family of origin, and how that may impact an individual's susceptibility to trauma later in life is really important.

Moving on to moral injury. So we need to recognize that moral injury is a prevalent concern among the broad range of symptoms that may manifest following traumatic exposure.

Moral injury is an aspect of psychological disturbances that is often affiliated with exposure to traumatic events. So this is one of the challenges is that figuring out how to separate traumatic brain injury with PTSD, with more injury when one event could have caused all three. I often describe the trauma, the word trauma in traumatic brain injury refers to a physical trauma. Or the word trauma in post-traumatic distress disorder talks about a psychological trauma.

So moral injury is affiliated or often affiliated to exposure to traumatic events. It doesn't always mean exposure to combat events. For example, in 2005, active military and a guards in Reserve were activated to support Hurricane Katrina in efforts to provide relief in Hurricane Katrina. As I've mentioned before, natural disasters and witnessing the aftermath of natural disasters is a significant cause for post-traumatic distress disorder. And I've had a number of Veterans who struggled with that. I've had probably maybe two or three who experienced that timeframe, whereas, you know, they were doing military stuff on U.S. soil, right? So stopping looting. Things like the military had to go from house-to-house to identify whether individuals in the house were deceased and they had to mark the house.

And, so, I had one Veteran who assumed that, and he was walking up to the house. And he saw a pair of feet sticking out the front door. And he steeled himself to address this situation. But as he approached, the gentleman sat up and surprised him, because he thought he was going to be working – or he was going to be interacting with

someone who was deceased and was surprised he was alive. But he found he was angry that the guy scared him. But he struggled with the moral impact of being angry that this man was alive. The gentleman was just trying to get some fresh air while he was sleeping.

And, so, these are the things that it's not just exposure to combat, but exposure to traumatic events.

Moral injury is described as perpetrating failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations. Anyone who is working with Veterans, I highly recommend that you do some research on moral injury. You get some understanding around moral injury. A book called "Achilles in Vietnam" is an excellent resource for that. It was one of the first publications to identify or in some ways codify what moral injury is. So understanding that moral injury and the moral decisions that we have to make when someone is in the military or even in combat, they're very, very significant.

We're not talking necessarily – well, we are talking about incidents such as Mili in Vietnam and Abu Ghraib detainee scandal in the Global War on Terror. And those were things that those individuals didn't grow up thinking that they were going to perpetrate war crimes, but ultimately did. But also individuals around them who might have failed to prevent those or those that bore witness to the agents, maybe they intervened someone doing this. But there's also the issue of what I describe as small moral injuries. You know, just the fact that there's no stop signs in Afghanistan. There's no speed limit in Iraq. So we get used to operating in a different set of laws when it comes to our rules of engagement. But now we have to come back to this nation of rules and laws and obey those rules and laws to integrate into society.

And for some Veterans, this is a big shift. Association between reports of atrocities and PTSD is greater than reports of the association between combat exposure and PTSD. Again, this is one of those issues just because someone has been to combat or even exposed to combat, if they engage in a fire fight and it was simply a "I was attacking them, or they were talking me." PTSD is not as prevalent or

reported as much as it is when those individuals who witness something that is against their own personal moral code.

Combat related guilt is associated with re-experiencing and avoidance symptoms of PTSD. And, so, this is, again, one of these things where do they overlap? There is some discussion that moral injury is not a diagnosis in the current DSM. There's some discussion about whether it is a subset of post-traumatic stress disorder, or it is a separate condition, or it's a combination of the two. But combat related guilt is associated with re-experiencing avoidance symptoms.

So things like anniversary. Memorial Day or anniversary, remembrance experiences where individuals will just say, I want to stay in the house all day. I want to shut-off social media. I don't want to be reminded of the traumatic loss that I experienced that I was unable to do this or do that.

Moral conflict with deeply held beliefs creates post event emotional distress, which impacts an individual's motivation to avoid cues that serve as reminders of the experience. So this is, again, this isn't the PTSD, I am avoiding things that cause my body to react, that cause the activation of the hairs to stand on the back of my neck, or loud noises that automatically make me drop to the ground. This is more of avoiding those things that remind me of things that I did wrong, or things I didn't do, or couldn't stop when I was deployed.

So there are number of assessments for moral injury. I highly recommend that these are very good to sort of unpack what some of these issues are. So the moral injury events scale. The moral injury questionnaire – military. And then the expressions of moral injury scale – military. As I've said, I think the first moral injury really first emerged as a concept. It was first defined by Brett Litz and his colleagues in 2009. And really over the last 10 years or as these scales have emerged, there is not a number of studies looking at evidence-based treatment and their effectiveness on moral injury. But right now the condition is so new as far as the research goes that we're still trying to get our hands around it.

I have worked with justice involved Veterans since 2015, and I found that including the assessments started out with a moral injury event scale, but the expressions of moral injury scale with Joseph Courier and his colleagues have been very, very beneficial in helping to, one, describe to the Veteran, the Service member, what they're experiencing. And I've had individuals actually take this assessment, as I've mentioned before, Veterans are very assessment sophisticated. But when they are posed these particular questions such as the ones in the expressions of moral injury scale, they're surprised. Like nobody has ever asked me this before, and I never asked myself this before. And this is describing me to a T.

Moral injury is a very significant aspect. It's something that impacts our substance use. Again, we're trying to drown the shame. Things like, you know, I've loss five buddies, so I have to take five shots to honor their memory. And so moral injury is a very, very significant aspect that we need to pay attention to.

The Veteran that I mentioned who was in Hurricane Katrina, whenever I presented him with a description of moral injury, he got very angry. And he got angry because he said, well, why haven't I heard about this before? And he described it as, I just feel like I'm Ben Franklin and I discovered lightening. He's like this is something that describes everything that I'm dealing with. Again, someone that have been treated or told he had PTSD, but he didn't have some of the criterion of PTSD as far as avoiding of the triggers. But for him, it was much more moral injury.

And next under assessment of presenting concerns, we need to understand that trauma, the importance of assessing trauma in all military personnel given service-related injuries are not always combat related injuries. And that secondary trauma, vicarious trauma, and pre-existing trauma may exist.

This now is going into discussing the adverse childhood experience. Some studies indicate that military Service members have a higher total adverse childhood experience scores than civilians. Higher ACE scores are associated with increased risk for adult health factors, physical health factors such as smoking, obesity, and reduced health-related quality of life. One common reason for the military to escape chaotic or dysfunctional home environments, especially for female Service members.

And then adverse childhood experiences could impact adult psychological health in a number of ways, such as childhood trauma increasing the likelihood of adult victimization.

We know, as we're advancing in neuroimaging that maltreatment in childhood is associated with neurological dysregulation. Potentially interfering with the development of an emotional learning and coping skills. Caregivers and family members of Service members and Veterans are also susceptible to secondary and vicarious trauma. So, again, we've talked a lot about Service members themselves or act of duty Service members or Veterans. But the family is also a consideration as well.

And, so, caregivers with compassion fatigue or those individuals who are exposed to the symptoms of some of these concerns can develop secondary vicarious trauma. Caregivers of persons who have experienced psychological trauma may become indirect victims of the trauma. It's also a challenge when we talk about invisible wounds of war, someone can be recognized as a caregiver with someone who has obvious physical catastrophic injuries such as losing a limb or a paralyzation. Whereas, you know, your husband or your wife looks perfectly fine could be a stigma that they experience.

Secondary traumatic stress, the natural and consequent behavior and emotions resulting in knowing about a traumatizing event experienced by a significant other. The stress resulting from helping or wanting to help a traumatized or suffering person. Again, this is one of those things of, you know, I know what my husband or wife went through when I was in the military or when they were in the military. I want to help them, and I don't know how.

Vicarious traumatization is described as a transformation of cognitive beliefs as a result of empathetic engagement with the Service member or Veteran's traumatic experiences. This is where it's a position "Be aware of thy self." And in some cases, positions, heal thy self. But one of the issues in with mental health professionals in working with Service members and Veterans is being careful of not experiencing or recognizing the signs of vicarious traumatization based on the empathetic engagement, or clinicians who anyway not have served, and this is especially true for clinicians who

have served in the military and may have experienced combat. This is something that I, and some of my other clinical colleagues who have served in the military, we talk about it often as being very, very aware to not allow what we experienced in combat impact how we interact with the individual, impact on an emotional level how that impacts our client work. So we have to be very, very aware that we're not re-traumatizing or engaging in vicarious or receiving vicarious traumatization.

So next up, I will turn it over to Samson for Polling Question 4.

>> SAMSON TEKLEMARIAM: Thanks, Duane. Everyone, you will see the fourth polling question, fourth and final pop up on your screen. It asks: Military sexual trauma is reported at equal rates for male and female survivors of MST. You'll see four, or sorry, five answer options there. It looks like half of you already answered. We'll give you just about 5 more seconds. All right. Thank you. It looks like about 85% of you have voted. Thanks for interacting with your presenter in this poll. Again, if you have any questions, please feel free to send them into the questions box or the Chat panel. And we will answer them in the order in which they are received.

I'm going to go ahead and close this poll and share the results, and turn this back over to Duane.

>> DUANE K. L. FRANCE: Again, and I think those of us who have worked with both male and female survivors of military sexual trauma, the research shows that female survivors do under report. Military sexual trauma Male survivor of military sexual trauma under report at even greater level.

And, so, it's one of these – this is one of the challenges when it comes to addressing military sexual trauma, especially, in Veterans. And, again, anecdotally from my experience, the several Veterans that I have worked with with military sexual trauma were the ones here, the three I'm specifically considering for male military sexual trauma were all victimized as a child. So we talk about the revictimization as an adult experiencing military sexual assault, or excuse me, sexual assault as a child. But, yes, we need to understand. And this isn't to say that for every female that comes into our therapy space that we need to assume that they experience military sexual trauma

anymore than for the male Veterans. But it is important to understand what it – that rates are reported to be lower.

So, when it comes to military sexual trauma, clinicians have to be aware of current military sexual trauma rates among women and men Service members and recognize that increased mental health disorders are often observed in those who have experienced military sexual trauma.

Again, at the bottom of the page, Veteranmentalhealth.com/NAADAC5, I have all of the references that are linked. I actually have the Department of Defense's annual suicide report on sexual assault in the military for fiscal year 2018. That's linked there and you can go and do that. If you find yourself experiencing a greater number of military sexual trauma clients, it's very, very encouraged that you go and you look at what the current military sexual trauma rates are. Or even were at the time when the individual experienced them.

The Veterans Health Administration describes military sexual trauma as sexual assault or repeated, threatening sexual harassment during military service. Veterans who report MST are at greater age-adjusted risk for suicide and self-injury. Military sexual trauma is also associated with increased risk for other mental health conditions such as anxiety, depression, and PTSD.

Treatment for military sexual trauma requires integrated treatment strategies, coordinating both primary care and mental health services for both male and female survivors of military sexual trauma. So it's very important for us to understand that we need to make sure that it's not just psychological. It is physical. It's substance use and a number of different aspects.

Accord to get 2018 Department of Defense annual report on sexual assault on the military, the prevalence of sexual assault for active duty women has increased for women but is unchanged for men. This was, again, according to 2018. The prevalence of sexual assault has increased. Again, there is some debate about whether this is increased reporting due to programs such as the image there, Sexual Assault

Prevention and Response. Or the incident is actually rising, or the fact that it was unchanged for men. It meant that reporting didn't go up.

Sexual assault in the military occurs most often between junior enlisted acquaintances who are peers or near peers in rank. So this is one of the things that it's critical to understand. As a lot of times, we may hear anecdotally of, you know, seniors and subordinates, you know, seniors forcing subordinates for quid pro quo, for example, engaging in unwanted sexual contact. But according to the survey, it really is for example, you know, we went out to the club and we were acquaintances, and it happened, sexual assault happened without consent from peers that, you know, friends that you hang out with. So acquaintance rape, and acquaintance assault is still very, very prevalent.

Only about one in three Service members report their experience of sexual subtle to a DOD authority. So this is, again, one of those issues of reported incidents versus actual incidents is we can only track that which is reported. And if an assault is not reported, then we don't necessarily have the numbers. So any of the numbers that we have in military sexual trauma is understood to be underreported.

Workplace climate influenced the risk for sexual assault. And, so, toxic leadership, for example, is a problem. And toxic leadership, toxic workplace environment does increase the risk for sexual assault.

Women who experienced sexual harassment were at three times greater risk for sexual assault than average. Men who experienced sexual harassment were at 12 times greater risk for sexual assault than average. So this is, again, one of the issues of sexual harassment versus sexual assault. A greater number of women might likely experience sexual harassment, and that raises their risk for sexual assault.

Again, this is very critical. In my experience in some of the Veterans that I've worked with where they feel like they put them in this position, or that they didn't stop something, or they blame themselves in some cases that this happened. Whereas, they might not have understood the risk that they were experiencing if there was systematic sexual harassment. And, again, that's a very critical statistic when it comes

to male Veterans. Some of the multiple sexual assault is associated with hazing, with bullying, let's say, or with, you know, maybe punishing someone for a perceived transgression. Where it may not be, you know, intercourse-specific in nature.

But if an individual is experiencing sexual harassment, they are 12 times greater, male are 12 times greater for risk for sexual assault on average.

And then next is suicide. We must become knowledgeable of the variances in current suicide statistics among Active Duty, Reserve components, Veterans, and their families when compared to national statistics. So according to the 2019 National Veteran Suicide Prevention Annual Report, the number of Veteran deaths by suicide exceeded 6,000 each year from 2008 to 2017. In 2017, the suicide rate for Veterans was 1.5 times higher than the rate for non-Veterans, adjusted for age and gender. That's by suicide with firearms as a method accounted for 7 0.7% of male Veteran suicide deaths and 43.2% of females. A national average of 2.5 suicide deaths per day occurred among currently drilling National Guard and Reserve Service members who were never federally activated.

So a lot of these numbers really indicate that we need to understand what we need to do to intervene. Are we having those discussions about means of safety when someone is a suicidal crisis? Are we assuming that, you know, male deaths by suicide are going to occur by firearm, whereas, a female Veteran is susceptible as well.

A change in reporting caused the VA to revise the number of Veteran deaths by suicide from 20 to 17. So this is something that, perhaps for me, it might be fingernails on a chalkboard. Many people still refer to this as 22 a day. Well, the 22 a day number was based off of a partial initial research done in 2013 that as we, I think, discussed in – whereas, I discussed. That didn't include, umm, Texas and California, two of the states with the largest number of Veterans. And, so, that 22 a day number was not representative. It was just the initial research.

The 20 a day number was identified several years ago by the Department of Veterans Affairs. But that actually had included the the active Service member and drilling guard and Reserve guard as death. And, so, now the number is actually 17

Veterans a day, and nearly 3 Active Duty or drilling military reserves, that's actually up from 16 Veterans a day in 2017. And, so, while the reporting numbers have changed, and really, we need to dig into this. Although it is confusing, although the reporting – the way we reported it changed to make it appear that suicide numbers dropped from 17 to 18, they actually increased by one per day.

According to the 2018 DOD annual suicide report. So this is actually discussing the Active Duty, and Drilling Guard, and Reserve rates of suicide in 2018 increased in the active component over the past five years while remaining steady in reserve components. Active Duty and currently Drilling Guard and reserve deaths by suicide occurred at rates that were roughly equal to the general U.S. population. Characteristics of current military deaths by suicide, they are primarily enlisted under the age of 30, male, and died by firearm.

And then 2018 was the first time that suicide rates among military spouses was reported, with the rate of 11.5 deaths by suicide per 100,000 of the population. Again, this is looking at our military affiliated clients. We don't know the number of – excuse me, we don't know the number of Veteran's spouse death. That's definitely included in the general population of any one particular area. But being involved and we think back to the secondary trauma or even the vicarious trauma that those are greater susceptibility for suicide.

So, usually when we're talking about suicide numbers, and rates, and deaths by suicide, it raises more questions than we have answers to. But identifying these gaps such as what is the -- for many locations, we don't even know how many Veterans are actually in your county or in your city. What is the Veteran suicide rate in your county or in your city? What is the military spouse or Veteran spouse suicide rate? Or suicide in the population that's militarily affiliated. This is definitely something that if we think about the public health approach, first we have to define the problem. And defining the problem in the military situation or military population is and continues to be an evolving task.

So now I would hand it over to Samson and attempt to answer some of your questions.

>> SAMSON TEKLEMARIAM: And Duane, before we jump into the Q&A, I'll just let you speak real quick to your quote and the references and then we'll go to the Q&A.

>> DUANE K. L. FRANCE: Sure, yes, I think it's slipped around a little bit. Dr. Rajeev Ramchand who was formerly with Rand, and then for a while was doing assessments with the Veterans network and that was with the Bob Woodruff Foundation. A very poignant statement.

"Raising mental health awareness is great. But I worry about a society in which we are all trained to think that the person next to us is about to take their own lives. What about training to promote emotional intelligence? Or policies to reduce rather than simply cope with stress?"

So this is the idea of how do we increase wellness and keep people from getting into a suicidal crisis rather than just, it would be a very bleak world if as I went to buy my coffee, or pick up lumber at the hardware store, that I'm automatically assuming that the individual across from me is at-risk for suicide. So we really have to look at this and say, yes, we want more people to be aware of accessing mental health. But we want to be able to increase wellness rather than always being concerned about the illness. Samson mentioned here the reference. Veteranmentalhealth.com/NAADAC5 has all of these references and has them linked so that you can actually dive a little deeper into something that may have caught your eye. And now we will do the end of session Q&A.

>> SAMSON TEKLEMARIAM: Awesome. Thanks, Duane. Sorry about that, I moved things a little. First I'll try to get into these so we can hopefully get all of them. The first question is: Is the CAPS PTSD scale still seen as the gold standard for this population? It was linked to the DSM-4, but was it ever updated for the DSM-5?

>> DUANE K. L. FRANCE: You know, I think there are a number of really good assessments. When I say we, my clinic provide support for the local Veterans court. And we use the trauma screening inventory 2, which didn't just look at PTSD, but it looks at a wide range of things. But I think that the CAPS is still effective. There are a number of screenings to, you know, a five question screening that will then lead to later assessments.

>> SAMSON TEKLEMARIAM: Great, thanks, Duane. And your trainings are the first I've ever heard of moral injury. Can you repeat that recommended author again on moral injury?

>> SAMSON TEKLEMARIAM: Yes, that's unfortunate, but not surprising. Again, this is – this is something that it has emerged. And when I first read it, a light bulb went off. When I first heard about it, a light bulb went off. And, so, it's Brett Litz and his colleagues. I've got – I will ensure that the link – but Brett Litz and his colleagues in 2009 wrote an article which define moral injury. Brett Litz and Dr. Shira Maguen.

Dr. Litz is out of University of Boston, I believe. And Dr. Maguen is with the Palo Alto VA in California. So anything written by Dr. Litz and Dr. Maguen is a very, very good resource. But Jonathan Shay who worked with Veterans, Vietnam Veterans in the '80s, he wrote Achilles in Vietnam in the early to mid-90s, I think. And was really one of the first ones to identify moral injury as a concept.

So Jonathan Shay, Brett Litz, and Shira Maguen.

>> SAMSON TEKLEMARIAM: Thanks, Duane. And one last one. I may have missed this earlier, but is there anything different that counselors need to do? Instead of our usual approach when assessing risk of suicide and our response to that risk?

>> DUANE K. L. FRANCE: You know this is actually something that a colleague of mine, Dr. Stacey Freedenthal, who has an excellent blog called "Speaking of Suicide." She and I have had the discussion that beyond risk assessment, we don't – we're not really trained to properly respond to suicide risk in the clinical space in our graduate programs.

This is something that is at great risk for this population. I usually, within the first three sessions, I talk about the Comprehensive Veteran Mental Health Model. I talk about the continuum of suicide from vague ideation all the way to suicidal acts. And I talk about the neurological basis of behavior. So one of it is to, of course, put it out there to say, hey, this may come up. We need to talk about it, and we need to talk about what will happen, and build a trust if you do get to a place where I don't feel you can keep doing this. Suicide can be a touchy subject for counselors. And, so, I think

one of the issues, just like with anyone else is getting comfortable talking about the situation, and simply making it part of the conversation.

>> SAMSON TEKLEMARIAM: And, everyone, in order to access this CE quiz, please view the entire training and listen for the password. The password is revealed or has been revealed in three separate sections. Here, I'll share with you the final last part of your password. So the third part, last part of your password is [redacted] Again, [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

Of course if you missed any part of this password to access the CE quiz, you will have access to the archived recording. GoToWebinar will send you an email about one hour after the live recording with a watch recording hyperlink at the bottom of the email. You can click on that link and review the training to capture any part of the CE quiz that passed or you may have already missed.

One last time, the third if final part of your three-part password to be entered into your CE quiz is one word. It's all lowercase. The last part is [redacted].

All right. And thank you, Duane. Thank you, everyone, for your participation. As we close out, please make sure to take just one minute to complete the brief post webinar survey. Once we close the webinar, it will pop up on your screen. And if you do not see it, no worries. About one hour after the live webinar is completed, you will receive a "Thank You" for attending automated email from GoToWebinar. And within this email is the link to the post webinar survey.

As we build out our annual specialty training series and NAADAC webinar series, we'll use your feedback to design targeted learning experiences for addiction treatment professionals. And also if you have not already done so, you can visit Amazon.com now or Duane's website. Www.veteranmentalhealth.com to continue your learning journey on this topic.

You'll see "Combat Vet Don't Mean Crazy: Veteran Mental Health and Post-Military Life. And "Head, Space, and Timing," which is also the name of Duane's, umm, -- I was about to say blog. It's also the name of Duane's podcast. And that book is

Headspace and Timing, Veteran Mental Health from a Combat Veteran Perspective. Also coming soon is Duane's third book titled “Military in the Rear-View Mirror.” Really looking forward to that one touching on the concepts of our Veteran clients paying more attention to what occurred in the rear-view mirror versus the potential of what’s ahead of them. And how we can partner with them in the transition to post-military life.

If you have not done so, please visit our website or bookmark this page dedicated to this specialty online training series. It is www.NAADAC.org./military-vet-training-webinar-series.

You’ll see the website at the top of the screen. And then you will also see that our next and final part of the 6 part series is a review on using what works or review of evidence-based treatment for military populations on December 7, 2019, from 12 noon to 1:30 p.m. Eastern Standard Time.

As a reminder, if you would like to access the CE quiz, it is available now on the website. Please maintain records of your invoice and receipt of payment if you wish to pursue the Certificate of Achievement for addiction treatment in military and Veteran culture. If you have any problems, just feel free to email us at any time. CE@NAADAC.org. That’s C as in cat. E as in echo. @NAADAC. And if you have not yet joined the NAADAC, you can visit www.NAADAC.org/join. Or email us any time. NAADAC@NAADAC.org to learn more about the countless benefits of becoming a NAADAC member.

Thank you, everyone, for participating in this specialty training. And, Duane, thank you for your valuable expertise and your service. I encourage you to take some time to browse our website, learn how NAADAC helps others. And stay connected with us on LinkedIn, Facebook, and Twitter.

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