

*Defense Centers of Excellence for Psychological Health and  
Traumatic Brain Injury (DCoE) Webinar*

**Post-deployment Gender Differences in PTSD,  
Unhealthy Drinking**

October 27, 2016  
1 – 2:30 p.m. (ET)



# Presenter, Moderator



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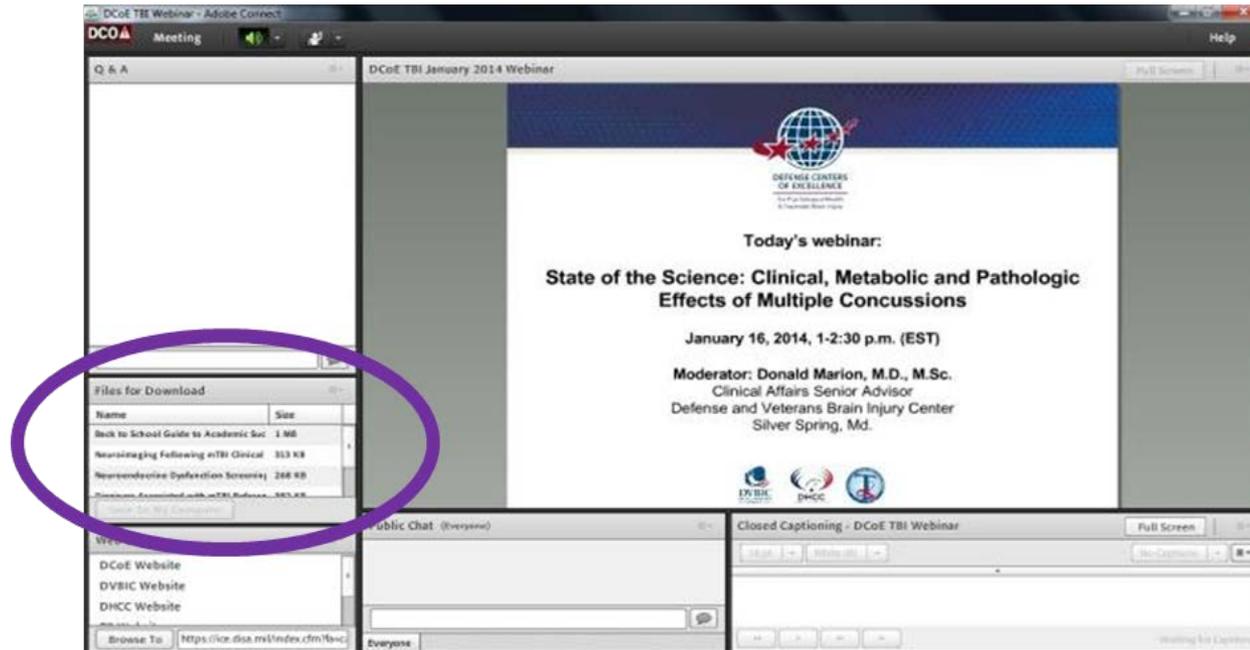
Demietrice L. Pittman, Ph.D., MAJ, MS (moderator)

***“Medically Ready Force...Ready Medical Force”***

# Resources Available for Download



Today's presentation and resources are available for download in the "Files" box on the screen, or visit [dcoe.mil/webinars](http://dcoe.mil/webinars)



***"Medically Ready Force...Ready Medical Force"***

# Webinar Details



- Live closed captioning is available through Federal Relay Conference Captioning (see the “Closed Captioning” box)
- Webinar audio is not provided through Adobe Connect or Defense Collaboration Services
  - Dial: CONUS **888-455-0936**
  - International **773-799-3736**
  - Use participant pass code: 2431998
- Question-and-answer (Q&A) session
- Submit questions via the Q&A box

# Continuing Education Details



- All who wish to obtain continuing education (CE) credit or certificate of attendance, and who meet eligibility requirements, must register by **3 p.m. (ET) October 27, 2016** to qualify for the receipt of credit.
- DCoE's awarding of CE credit is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families.
- The authority for training of contractors is at the discretion of the chief contracting official.
  - Currently, only those contractors with scope of work or with commensurate contract language are permitted in this training.

# Continuing Education Accreditation

(continued)



- This continuing education activity is provided through collaboration between DCoE and Professional Education Services Group (PESG).
- Credit Designations include:
  - 1.5 AMA PRA Category 1 credits
  - 1.5 ACCME Non Physician CME credits
  - 1.5 ANCC Nursing contact hours
  - 1.5 CRCC
  - 1.5 APA Division 22 contact hours
  - 0.15 ASHA Intermediate level, Professional area
  - 1.5 CCM hours
  - 1.5 AANP contact hours
  - 1.5 NASW contact hours

# Continuing Education Accreditation

## (continued)



### **Physicians**

This activity has been planned and implemented in accordance with the essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME). Professional Education Services Group is accredited by the ACCME as a provider of continuing medical education for physicians. This activity has been approved for a maximum of 1.5 hours of *AMA PRA Category 1 Credits*™. Physicians should only claim credit to the extent of their participation.

### **Nurses**

Nurse CE is provided for this program through collaboration between DCOE and Professional Education Services Group (PESG). Professional Education Services Group is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for a maximum of 1.5 contact hours of nurse CE credit. Nurses should only claim credit to the extent of their participation.

### **Occupational Therapists**

(ACCME Non Physician CME Credit) For the purpose of recertification, The National Board for Certification in Occupational Therapy (NBCOT) accepts certificates of participation for educational activities certified for AMA PRA Category 1 Credit™ from organizations accredited by ACCME. Occupational Therapists may receive a maximum of 1.5 hours for completing this live program.

### **Physical Therapists**

Physical Therapists will be provided a certificate of participation for educational activities certified for AMA PRA Category 1 Credit™. Physical Therapists may receive a maximum of 1.5 hours for completing this live program.

# Continuing Education Accreditation

## (continued)



### **Psychologists**

This Conference is approved for up to 1.5 hours of continuing education. APA Division 22 (Rehabilitation Psychology) is approved by the American Psychological Association to sponsor continuing education for psychologists. APA Division 22 maintains responsibility for this program and its content.

### **Physical Therapists**

Physical Therapists will be provided a certificate of participation for educational activities certified for AMA PRA Category 1 Credit™. Physical Therapists may receive a maximum of 1.5 hours for completing this live program.

### **Rehabilitation Counselors**

The Commission on Rehabilitation Counselor Certification (CRCC) has pre-approved this activity for 1.5 clock hours of continuing education credit.

### **Speech-Language Professionals**

This activity is approved for up to 0.15 ASHA CEUs (Intermediate level, Professional area).

# Continuing Education Accreditation (continued)



## **Case Managers**

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for up to 1.5 clock hours. PESG will also make available a General Participation Certificate to all other attendees completing the program evaluation.

## **Nurse Practitioners**

Professional Education Services Group is accredited by the American Academy of Nurse Practitioners as an approved provider of nurse practitioner continuing education. Provider number: 031105. This course is offered for 1.5 contact hours (which includes 0 hours of pharmacology).

## **Physician Assistants**

This Program has been reviewed and is approved for a maximum of 1.5 hours of AAPA Category 1 CME credit by the Physician Assistant Review Panel. Physician Assistants should claim only those hours actually spent participating in the CME activity. This Program has been planned in accordance with AAPA's CME Standards for Live Programs and for Commercial Support of Live Programs.

## **Social Workers**

This Program is approved by The National Association of Social Workers for 1.5 Social Work continuing education contact hours.

## **Other Professionals**

Other professionals participating in this activity may obtain a General Participation Certificate indicating participation and the number of hours of continuing education credit.

# Questions and Chat



- Throughout the webinar, you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. **Please do not submit technical or content-related questions via the chat pod.**
- The Q&A pod is monitored during the webinar; questions will be forwarded to presenters for response during the Q&A session.
- Participants may chat with one another during the webinar using the chat pod.
- The chat function will remain open 10 minutes after the conclusion of the webinar.

# Webinar Overview



Female service members play an integral role in U.S. military history and current operations. Women filled approximately 10 percent of all positions among deployed forces in recent conflicts. Yet, there is limited research specific to women’s combat experiences and post-deployment problems.

This presentation will introduce attendees to recent research that focused on female service members and post-deployment gender differences in posttraumatic stress disorder (PTSD) and unhealthy drinking. The speakers will discuss VA/DoD clinical practice guidelines and empirically supported treatments for PTSD and substance use disorders.

At the conclusion of the webinar, participants can:

- Discuss gender similarities and differences in combat exposure and post-deployment health problems
- Identify military and combat-related experiences associated with PTSD
- Demonstrate empirically supported treatments for PTSD and alcohol use for service members

# Rachel Sayko Adams, Ph.D., M.P.H.



- Dr. Adams is a scientist at the Institute for Behavioral Health at Brandeis University’s Heller School for Social Policy. Her research focuses on alcohol use after traumatic brain injury, and the postdeployment psychological health of military members.
- Dr. Adams has been a co-investigator on the Substance Use and Psychological Injury Combat Study (SUPIC), which examined the impact of early treatment for postdeployment substance use and mental health problems with long-term postdeployment outcomes

# Mary Jo Larson, Ph.D., M.P.A.



- Dr. Larson is senior scientist at the Institute for Behavioral Health, Brandeis University where she conducts a portfolio of research on military members and families. She served on the IOM Committee on Substance Use Disorders in the U.S. Armed Forces, and the IOM Committee on the Assessment of Resiliency and Prevention Programs for Mental and Behavioral Health in Service Members and their Families.
- With NIDA funding (R01DA030150), Dr. Larson developed the Substance Use and Psychological Injury Combat Study (SUPIC). With funding from NCCIH, Dr. Larson is PI for continued analyses with the SUPIC cohort to examine the use of opioids and complementary and integrative medicine when treating Army members with chronic pain (R01 AT008404; SUPIC-PM).

# Nikki R. Wooten, Ph.D., L.I.S.W-CP



- Dr. Wooten is an Assistant Professor and the Military Specialization, Chair, at the University of South Carolina's College of Social Work. She combines over two decades of clinical social work experience with her military background to conduct research on post-deployment health and behavioral health problems and service utilization in military and veteran populations.
- She is principal investigator of *Behavioral Health Care in Army Warrior Transition Units* (NIDA K01DA037412), which examines behavioral health problems and service utilization in Army Warrior Transition Units using DoD Military Health System and postdeployment health assessment and reassessment data among Army service members who returned from OEF/OIF/OND deployments from FY2008-FY2015.

# Postdeployment Gender Differences in PTSD and Unhealthy Drinking

## **Presenters:**

Rachel Sayko Adams, PhD, MPH, Mary Jo Larson, PhD, MPA,  
and Nikki R. Wooten, PhD, LISW-CP

## **Moderator:**

Demietrice L. Pittman, PhD, MAJ, MS

# Disclosures

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The authors have no relevant financial relationships to disclose.

The opinions or assertions are those of the authors and do not necessarily reflect the view of the United States DoD or NIH. DoD sponsorship of this study is through the Defense Health Agency.

# Polling Question 1

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My Primary discipline is:

- Primary care provider
- Rehabilitation provider
- Behavioral health provider
- Nurse
- Social worker/Case manager
- Other

# Polling Question 2

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Do you work with Military Populations?:

- Yes
- No

# Learning Objectives

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At the conclusion of this webinar, participants will be able to:

1. Discuss gender differences and similarities in combat exposure and postdeployment health problems
2. Identify the military and combat-related experiences associated with PTSD
3. Demonstrate empirically supported treatments for PTSD and alcohol use for military service members

# Women in the Military

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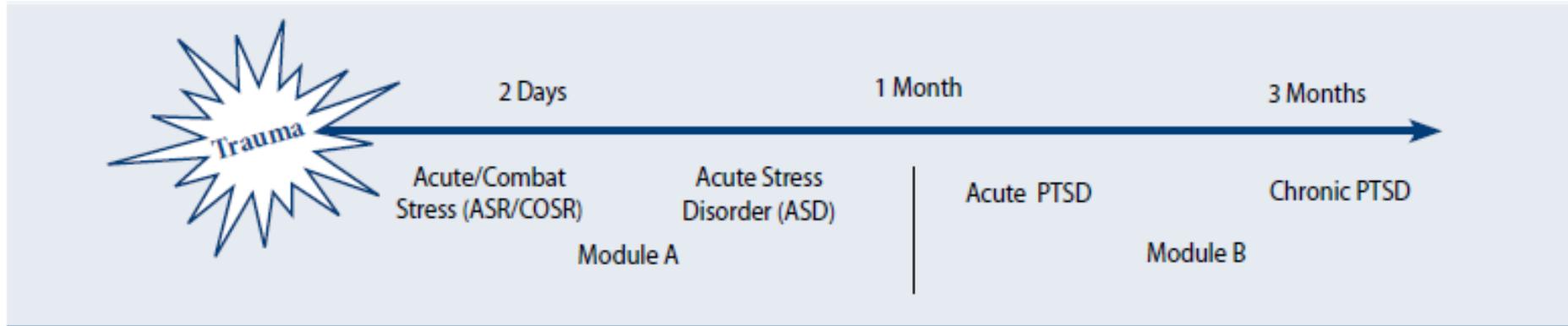
- Women have played an integral part in US military history
- Women represent an increasing portion of the military
  - In 2014, women comprised 15% of the active duty component and almost 19% of National Guard/Reserve (NG/R) component
- Women have comprised approximately 10% of deployments to Iraq/Afghanistan
- Until 2013, women were formally excluded from direct ground combat
  - Yet, deployments to combat zones inherently involve risk of combat exposures because of no front line
- Over 20% of women are in dual-military families

# Women's Combat Experiences and Postdeployment Problems Largely Unstudied

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- Most studies have focused on small convenience samples (e.g., one combat brigade)
  - Women too few in number (ignored or dropped)
- Studies generally do not report on women separately
- More research has been done on women veterans in the Veterans Health Administration (VHA)
  - Findings may be biased because many women do not utilize care in the VHA
- Requires analysis beginning in the DoD and following women after deployment longitudinally

# Post-Traumatic Stress Spectrum of Traumatic Stress Disorders



# PTSD Symptom Clusters

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## Symptom Clusters

- Re-Experiencing: intrusive memories, images or perceptions
- Flashbacks
- Nightmares
- Exaggerated emotional and physical reactions

## Avoidance/emotional numbing:

- Avoids activity
- Loss of interest
- Detached
- Restricted emotion

## Increased arousal:

- Difficulty sleeping
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

# PTSD Common Presenting Symptoms

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- Physical: Chronic pain, migraines, vague somatic complaints
- Mental: intoxication, anxiety, or depression
- Behavior: irritability, avoidance, anger or non-compliance, self-risk behavior, threatening or aggressive behavior
- Dissociative symptoms
- Change in function

# PTSD Prevalence Estimates

## General Population:

- Prevalence ranges from 5-6% in community-dwelling adults
- Lifetime prevalence of 6.8% in American adults
- Past year prevalence of 3.5% in American adults
- Lifetime prevalence of 3.6% in men and 9.7% in women
- Current prevalence of 1.8% in men and 5.2% in women

## Military & Veteran Populations:

- Vietnam veterans
  - Lifetime prevalence is 30.9% for men and 26.9% for women
  - Current prevalence is 15.2% for men and 8.1% for women
- Persian Gulf War veterans
  - Past year prevalence of 12.1%
  - Current prevalence ranges from 1.9-13.2%
- OEF/OIF veterans
  - Current prevalence ranges from 4-17%

# PTSD

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Moral injury: “Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009)

- Killing is a significant predictor of PTSD
- Difficulty forgiving oneself and negative religious coping are associated with PTSD symptom severity
- Combat-related guilt may be a mechanism through which combat-related abusive violence is associated with PTSD in Vietnam veterans
- Postdeployment PTSD symptoms may be a mechanism through which killing during combat is associated with the desire for self-harm among Iraq veterans

# Unhealthy Drinking - Definitions

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- **Binge drinking:** NIAAA definition of 5+ drinks per typical drinking occasion for males (4+ for females)
  - DoD postdeployment health assessments have used 6+ drinks for both males and females
- **At-Risk Drinking:** AUDIT-C positive screen if 4+ for males (3+ for females) out of 0-12 scale
- **Severe alcohol problems:** Score of 8+ on the AUDIT-C for males and females

# Unhealthy Drinking in the Military

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- Military members drink at higher rates than their same age peers in the general public
- Unhealthy drinking is associated with negative consequences in the military
- Risk factors are combat exposure, young age, enlisted pay grade, PTSD, and traumatic brain injury (TBI)
- Drinking may be used to self-medicate or cope, especially during reintegration postdeployment

Adams et al., 2012; Bray et al., 2010; Cobb et al., 2014; IOM, 2013; Mattiko et al., 2011; Santiago et al., 2010

# Brandeis Papers Addressing Learning Objectives 1 and 2

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## Paper Topics:

- Gender differences in pre-deployment diagnoses and treatment history
- Gender differences in combat exposure and postdeployment health problems
- Combat exposure and TBI as risk factors for PTSD and Unhealthy Drinking
- Missed opportunity for postdeployment alcohol problem prevention

# Pre-deployment Diagnoses and Treatment History

Journal of Substance Abuse Treatment 45 (2013) 257–265



Contents lists available at SciVerse ScienceDirect

Journal of Substance Abuse Treatment



Gender differences in substance use treatment utilization in the year prior to deployment in Army service members<sup>☆</sup>

Nikki R. Wooten, Ph.D., L.I.S.W.-C.P.<sup>a,b,\*</sup>, Beth A. Mohr, M.S.<sup>c</sup>, Lena M. Lundgren, Ph.D.<sup>d</sup>,  
Rachel Sayko Adams, Ph.D., M.P.H.<sup>c</sup>, Elizabeth L. Merrick, Ph.D., M.S.W.<sup>c</sup>,  
Thomas V. Williams, Ph.D.<sup>e</sup>, Mary Jo Larson, Ph.D., M.P.A.<sup>c</sup>

## Substance use diagnosis and treatment

- 12% of Army women and 14% of Army men who returned from deployment in FY2010 had received a substance use diagnosis during military service
- Army women were less likely than Army men to receive substance use treatment the year before deployment
- Gender disparity in substance use treatment and potentially unmet substance use treatment needs among Army women

# Pre-deployment Diagnoses and Treatment History

Adm Policy Ment Health  
DOI 10.1007/s10488-016-0744-3



ORIGINAL ARTICLE

## Pre-deployment Year Mental Health Diagnoses and Treatment in Deployed Army Women

Nikki R. Wooten<sup>1</sup> · Rachel Sayko Adams<sup>2</sup> · Beth A. Mohr<sup>2</sup> · Diana D. Jeffery<sup>3</sup> · Wendy Funk<sup>4</sup> · Thomas V. Williams<sup>5</sup> · Mary Jo Larson<sup>2</sup>

### Pre-deployment mental health diagnoses and treatment

- 26% of Army women returning from deployment in FY2010 had PTSD, mood, adjustment, or other anxiety diagnoses the year before deployment
- 83% received mental health treatment for these diagnoses
- Military women who had received any behavioral health treatment since 9/11/01 had 61% more pre-deployment outpatient mental health visits

# BRANDEIS SUPIC STUDY

*Substance Use & Misuse*, 48:863–879, 2013  
Copyright © 2013 Informa Healthcare USA, Inc.  
ISSN: 1082-6084 print / 1532-2491 online  
DOI: 10.3109/10826084.2013.794840

**informa**  
healthcare

ORIGINAL ARTICLE

## **Rationale and Methods of the Substance Use and Psychological Injury Combat Study (SUPIC): A Longitudinal Study of Army Service Members Returning From Deployment in FY2008–2011**

Mary Jo Larson<sup>1</sup>, Rachel Sayko Adams<sup>1</sup>, Beth A. Mohr<sup>1</sup>, Alex H. S. Harris<sup>2</sup>, Elizabeth L. Merrick<sup>1</sup>, Wendy Funk<sup>3</sup>, Keith Hofmann<sup>3</sup>, Nikki R. Wooten<sup>4</sup>, Diana D. Jeffery<sup>5</sup> and Thomas V. Williams<sup>6</sup>

# Brandeis SUPIC Study

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- Substance Use and Psychological Injury Combat Study (SUPIC)
- SUPIC cohort includes all Army soldiers returning from OEF/OIF deployments in FYs 2008-2011 (N=643,205)
- Followed for up to 3 years postdeployment, including into the Veterans Health Administration (VHA)
- Data received from the Defense Health Agency (DHA) and the Army's Patient Administration Systems and Biostatistics Activity
  - Deployment records, TRICARE eligibility & enrollment records, healthcare utilization data, postdeployment health assessments
- Dr. Thomas V. Williams from the Defense Health Agency is our DoD sponsor
- Funded by the National Institute on Drug Abuse (R01 DA030150)

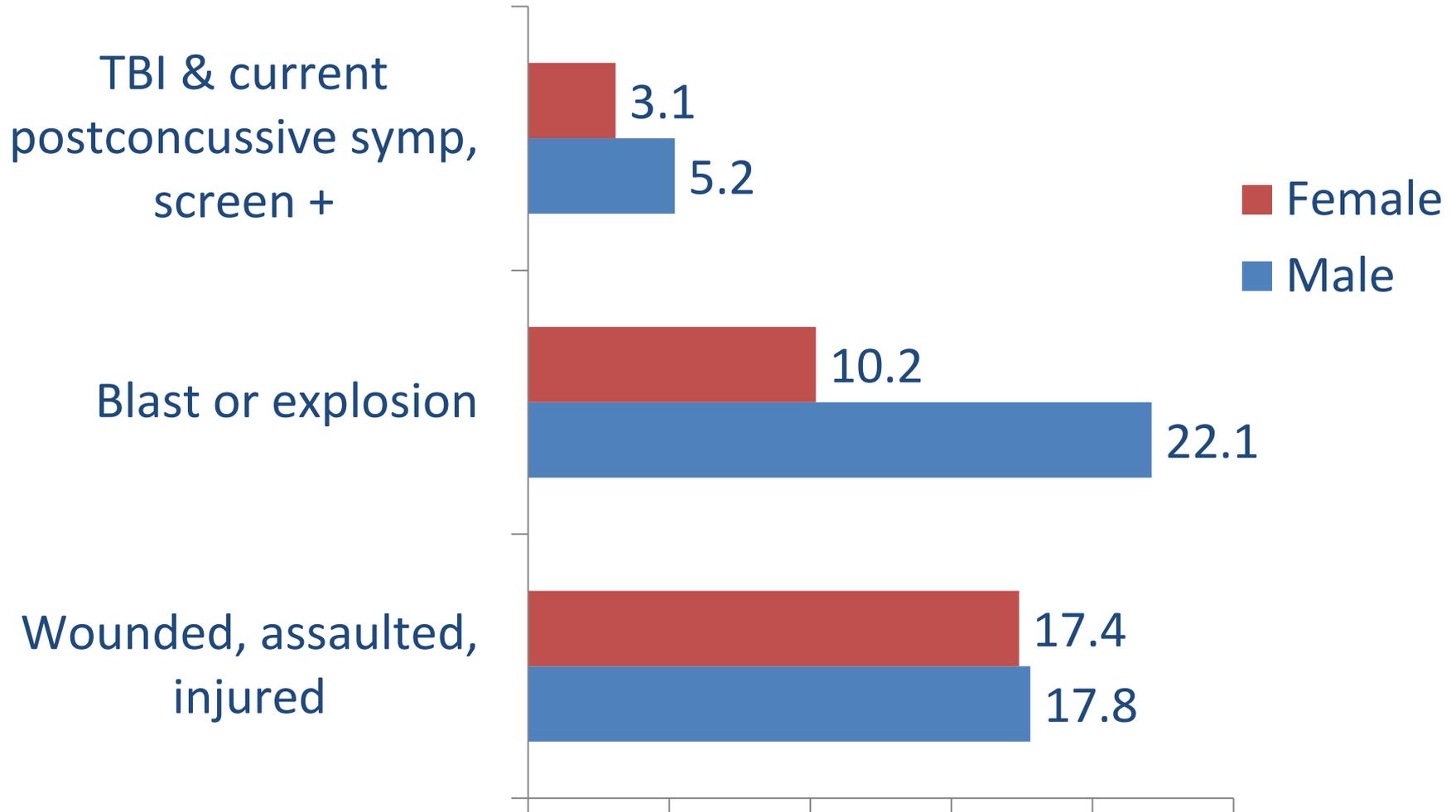
# Postdeployment Health Surveillance Data Sources

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- In 2003, the DoD implemented postdeployment health assessment questionnaires
  - **Initial Questionnaire:** completed within 30 days of deployment end-date (Postdeployment health assessment, PDHA)
  - **Follow-up Questionnaire:** completed 3-6 months postdeployment (Postdeployment health re-assessment, PDHRA)
- Includes service member self-report items, and a provider-assessment with opportunity for referral
- Captures information on PTSD, at-risk drinking, TBI, combat exposure, and other psychological health issues
- We analyzed the 2008 version questionnaires

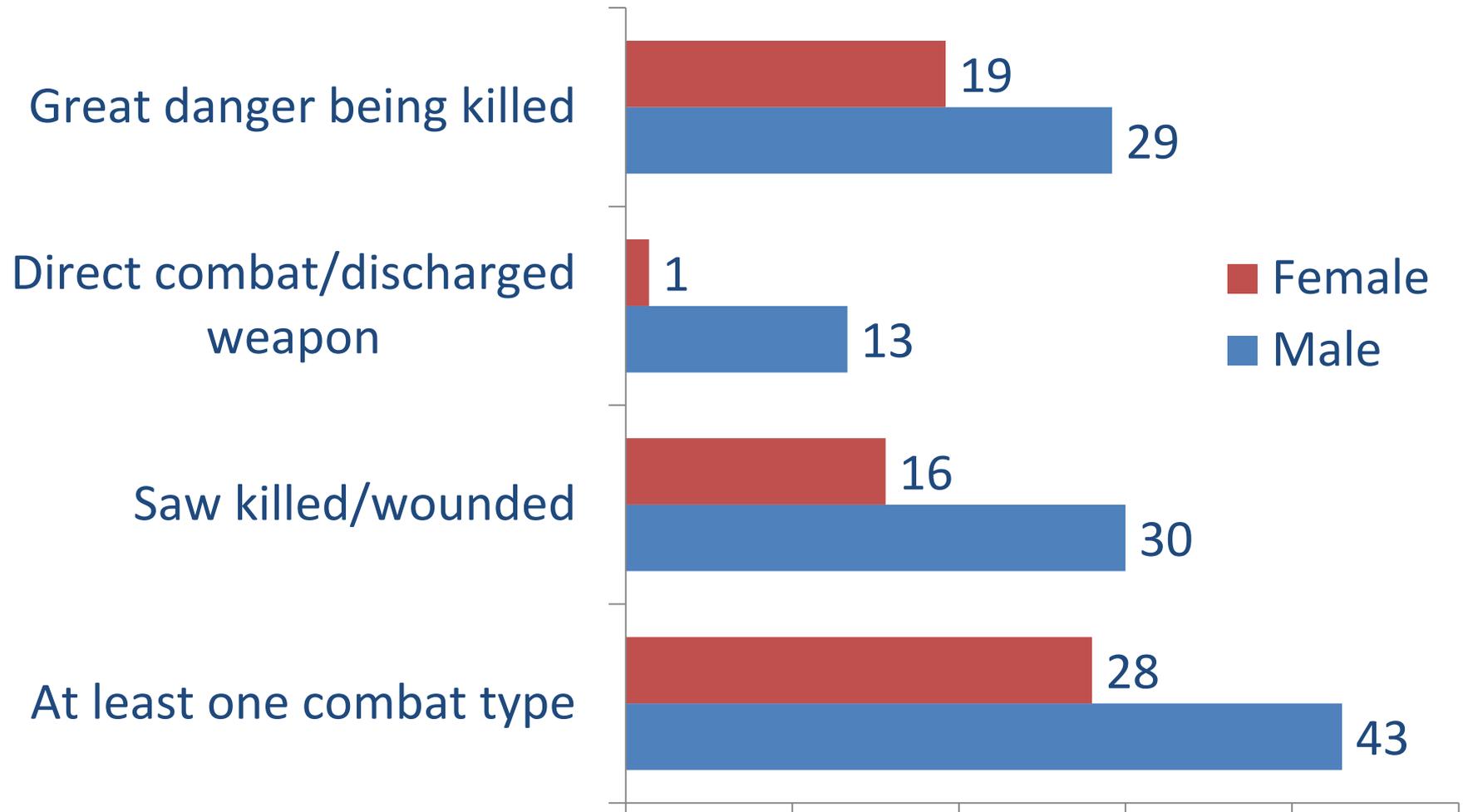
# SUPIC – PDHA FINDINGS BY GENDER

# Self-reported Injuries While Deployed, Index Deployment (%)

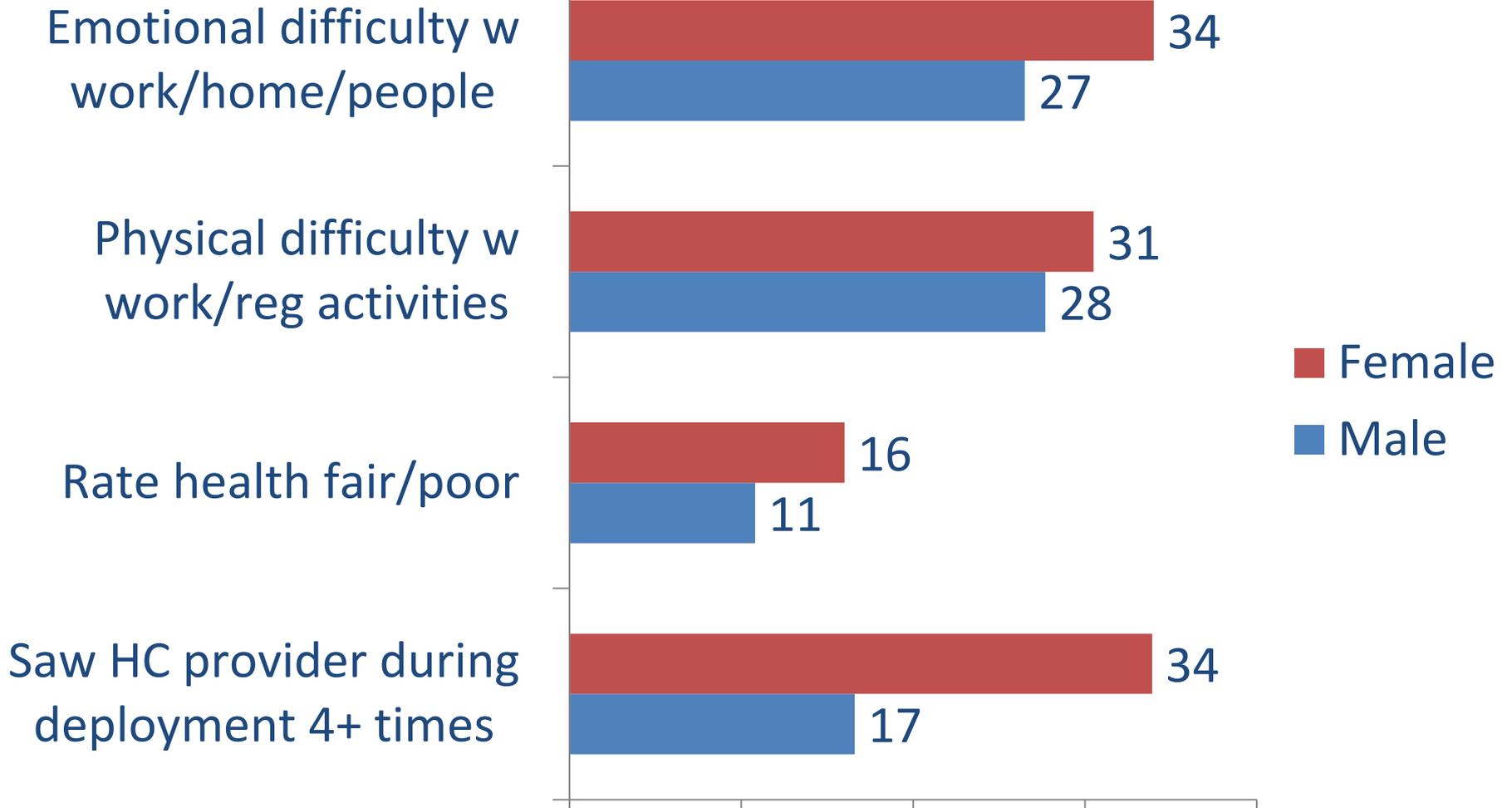


Army AD Enlisted SUPIC Study

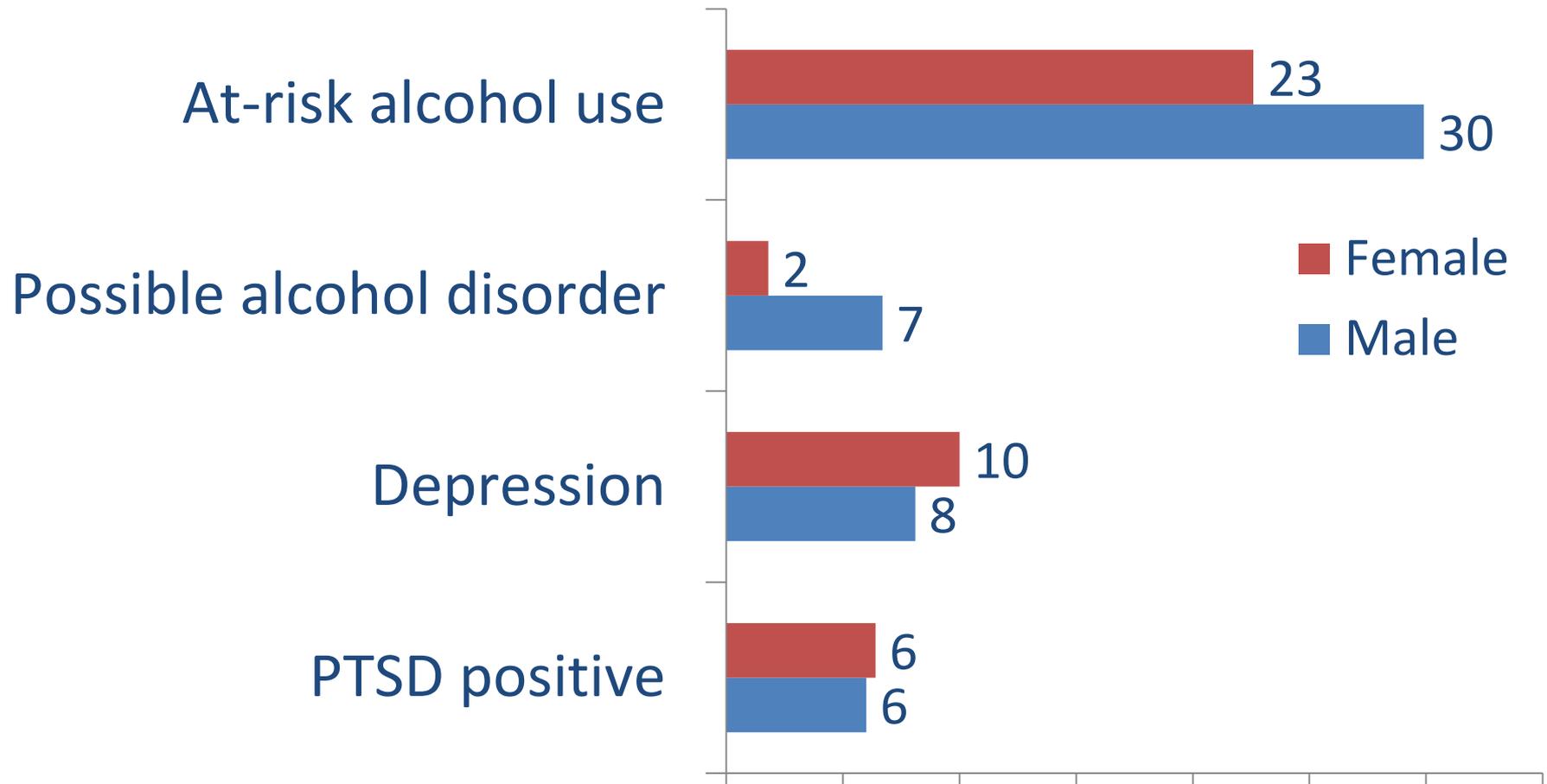
# Self-reported Combat Exposures, Index Deployment (%)



# Self-reported Postdeployment Health Problem (%)



# Screened Positive for Postdeployment Problems (%)



# Is Combat Exposure a Risk Factor for PTSD and At-risk Drinking Among Women?

*Journal of Traumatic Stress*  
xxxx 2016, 00, 1-9



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## **The Association of Combat Exposure With Postdeployment Behavioral Health Problems Among U.S. Army Enlisted Women Returning From Afghanistan or Iraq**

Rachel Sayko Adams,<sup>1</sup> Ruslan V. Nikitin,<sup>1</sup> Nikki R. Wooten,<sup>2</sup> Thomas V. Williams,<sup>3</sup> and Mary Jo Larson<sup>1</sup>

<sup>1</sup>Institute for Behavioral Health, Heller School for Social Policy and Management, Brandeis University, Waltham, Massachusetts, USA

<sup>2</sup>Military Social Work Research & Practice, University of South Carolina College of Social Work, Columbia, South Carolina, USA

<sup>3</sup>Decision Support, Defense Health Agency, Department of Defense, Falls Church, Virginia, USA

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**SUPIC sub-sample**: Female enlisted Army OEF/OIF deployers returning FY2008-FY2011 (n=42,397)

- 66% Active Duty (n=27,997) and 34% National Guard/Reserves (n=14,400)

# Combat Exposure and Injuries Associated with Behavioral Health Problems

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- Previous studies have found that combat exposure is associated with postdeployment problems including:
  - PTSD
  - Depression
  - At-risk drinking
- Yet, the generalizability to women members is limited because:
  - Females were only a small portion of deployed populations studied (i.e., 10%)
  - Studies generally relied on smaller, convenience samples

# Prevalence of Self-reported Injuries and Combat Exposure, by Component

	Active Duty Women N=27,997	NG/R Women N=14,401
Wounded, injured, assaulted or hurt	4,839 (17.3%)	4,174 (29.0%)
Encountered dead bodies, or saw people killed or wounded	4,345 (15.5%)	1,678 (11.7%)
Engaged in direct combat where you discharged a weapon	403 (1.4%)	83 (0.6%)
Felt in great danger of being killed	5,366 (19.2%)	2,654 (18.4%)
Constructed Combat Score		
0	17,220 (61.5%)	8,028 (55.8%)
1	7,441 (26.6%)	4,528 (31.4%)
2	2,569 (9.2%)	1,494 (10.4%)
3+	767 (2.7%)	350 (2.4%)

# Outcome Measures

- 1) Positive PTSD screen: Primary Care PTSD Screen, PC-PTSD
  - Positive if 3+ out of 0-4 scale
- 2) Positive Screen for At-Risk Drinking: AUDIT-C
  - Positive if 3+ out of 0-12 scale

## Prevalence of postdeployment behavioral health positive screens, by component

Positive Screens	Active Duty Women N=27,997	NG/R Women N=14,401
PTSD	1,798 (6.4%)	1,007 (7.0%)
At-Risk Drinking	6,323 (22.6%)	3,254 (22.6%)

# Adjusted Odds Ratios for Combat Exposure Score and Postdeployment Behavioral Health Problems, by Component (95% Confidence Intervals)

## Active Duty Women (n=27,997)

	PTSD	At-risk Drinking
Combat Exposure Score 0 (reference)	1.0	1.0
1	4.4 (3.8-5.0)***	1.3 (1.2-1.4)***
2	11.0 (9.5-12.7)***	1.7 (1.5-1.9)***
3+	20.7 (17.0-25.1)***	1.8 (1.5-2.1)***

## National Guard/Reserve Women (n=14,400)

	PTSD	At-risk Drinking
Combat Exposure Score 0 (reference)	1.0	1.0
1	4.2 (3.5-5.1)***	1.3 (1.2-1.4)***
2	13.6 (11.0-16.7)***	1.7 (1.5-2.0)***
3+	27.8 (21.0-36.9)***	1.6 (1.2-2.0)***

Models control for demographics (age, race/ethnicity, marital status, child dependents, rank, education) and deployment variables (occupation, FY end date of deployment, any prior deployments, TBI positive screen)

Results were significant at the: \*\*\* p≤.001

# Summary of Findings

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- Reports of being wounded, injured, assaulted or hurt are common among female enlisted members
- Other reports of combat exposure are also frequent, particularly encountering dead bodies or being in danger of being killed
- As the combat score increases, there is a significant association with PTSD and at-risk drinking
- For PTSD, there was a dose response relationship and a large effect

# Limitations

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- Few measures of combat exposure considering soldiers are returning from a combat zone
- We cannot explain why reports of being wounded, injured, assaulted or hurt are so common
  - No direct assessment of sexual assault on the PDHA
- Questionnaires are not anonymous and there may be incentives to under-report problems

# Implications and Future Research

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- Among the first population-level studies of AD and NG/R enlisted women to examine association of combat exposure with postdeployment problems
- Additional research needed on the types of combat exposure experienced by women and their unique needs associated with these exposures
- Need for additional sensitive screening to determine if assaults relate to sexual assault
- A high proportion of women who deploy to a combat zone may benefit from early prevention and confidential intervention for postdeployment problems

# Sexual Assault as a Risk Factor for PTSD and Alcohol Abuse

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- The 2012 WGRS found that 6.1% of females and 1.2% of males experienced unwanted sexual contact in the past year
  - USC includes a continuum of sexist behaviors, sexual harassment, and rape or attempted rape
- Over 50% of both females and males reported that the offender was a military coworker
- The DoD estimates that less than 20% of all military sexual assault events are reported to military authority
- Military sexual assault is a risk factor for PTSD and alcohol abuse

Cobb et al., 2014; Hankin et al 1999 JOTS; SAPRO, 2014; DMDC, 2013.

# TBI as a Risk Factor for Postdeployment Drinking and PTSD

*J Head Trauma Rehabil*

Vol. 27, No. 5, pp. 349–360

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## Frequent Binge Drinking After Combat-Acquired Traumatic Brain Injury Among Active Duty Military Personnel With a Past Year Combat Deployment

*Rachel Sayko Adams, MPH, MA; Mary Jo Larson, PhD, MPA; John D. Corrigan, PhD;  
Constance M. Horgan, ScD; Thomas V. Williams, PhD*

# TBI and PTSD

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- The same etiology that contributes to a TBI (e.g., injury) may contribute to the development of PTSD
- TBI and PTSD are highly correlated and the signs and symptoms associated with both conditions overlap
- TBI may increase the likelihood of developing PTSD and may complicate recovery from PTSD

IOM, 2012; Pietrzak et al, 2011; Hoge et al., 2008; Schneiderman et al., 2008

# TBI is a Risk Factor for Frequent Binge Drinking

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Data source: 2008 Department of Defense Survey of Health Related Behaviors among Active Duty Military Personnel (HRB Survey)

- Anonymous, self-report, and self-administered survey
- The odds of frequent binge drinking (binge drinking at least weekly in the past month) were increased among:
  - Males
  - Those with a history of TBI on the index deployment, especially those with a loss of consciousness of greater than 1 minute
  - Those with a PTSD positive screen

# Missed Opportunity for Alcohol Prevention

## Missed Opportunity for Alcohol Problem Prevention Among Army Active Duty Service Members Postdeployment

| Mary Jo Larson, PhD, MPA, Beth A. Mohr, MS, Rachel Sayko Adams, PhD, MPH, Nikki R. Wooten, PhD, LISW-CP, and Thomas V. Williams, PhD

1402 | Research and Practice | Peer Reviewed | *Larson et al.*

American Journal of Public Health | August 2014, Vol 104, No. 8

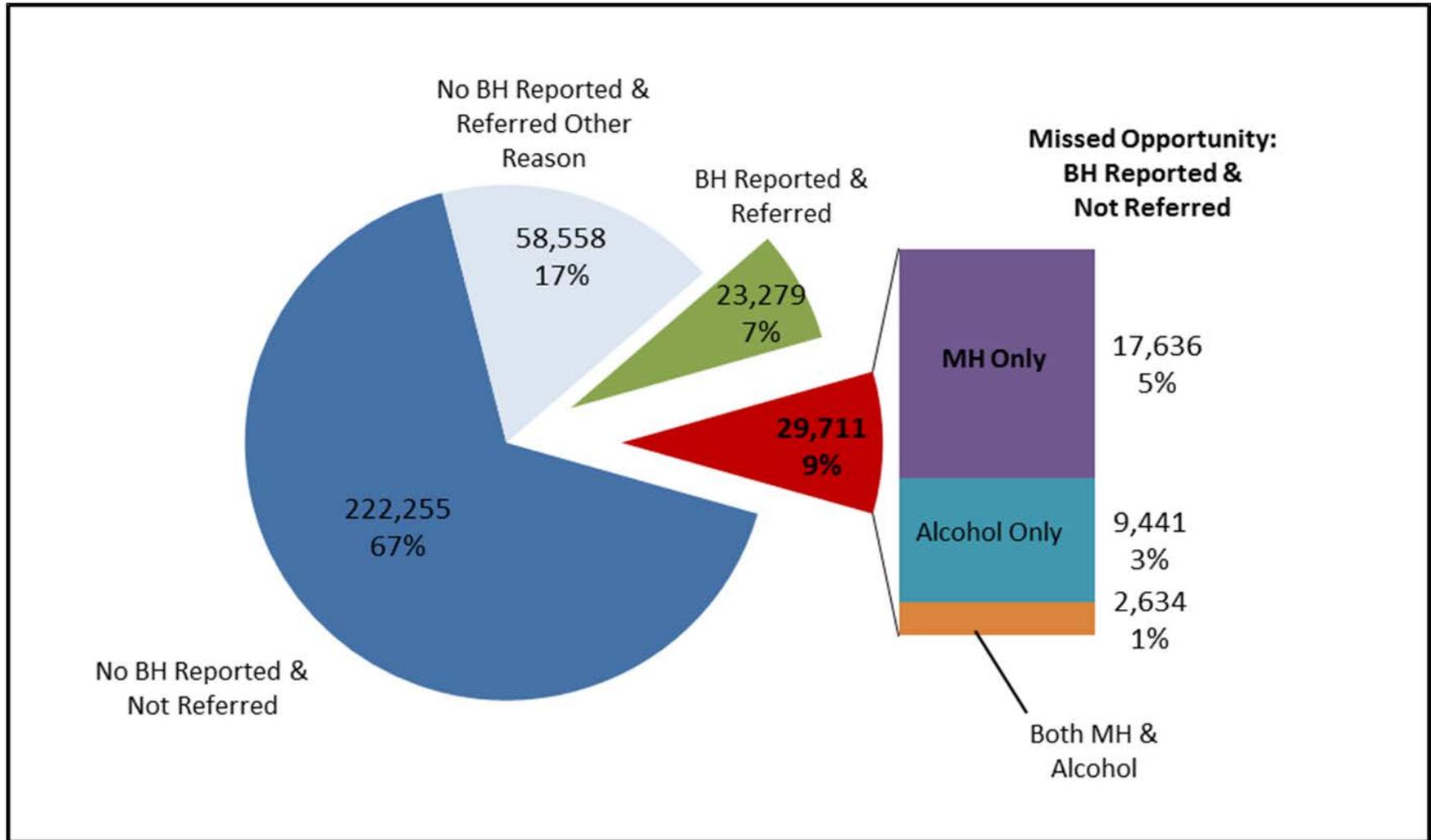
**SUPIC sub-sample**: Army Active Duty OEF/OIF deployers returning FY2008-FY2011 (n=333,803)

# Missed Opportunity for Alcohol Prevention

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- We found that 27-28% of females and males who had an AUDIT-C score of 7+ were not identified as having an alcohol problem by the interviewing provider during the PDHA
  - This reflects a missed opportunity for prevention of further problems
- Further, approximately 60% of soldiers with an AUDIT-C score of 8+ were not referred for a follow-up visit to primary care (results not stratified by gender)

# Postdeployment Behavioral Health (BH) Screening and Referral



# Implications

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- Even with underreporting based on self-report measures, many Army soldiers with positive screens are not referred for additional assessment and brief intervention
- To reduce missed opportunities associated with risky drinking (and other problems), must increase provider recognition that there are risks associated with positive screens
- Cannot rely on soldier self-report of own concern about alcohol use as basis of referral
- Insufficient information is recorded to know if provider recognition of problems is associated with provider discipline, training, etc.

# VA/DOD CLINICAL PRACTICE GUIDELINES

# VA/DoD Clinical Practice Guidelines

## *Management of Post-Traumatic Stress Disorder and Acute Stress Reaction* <http://www.healthquality.va.gov/guidelines/MH/ptsd/>

- Screening
  - Primary Care PTSD Screen (PC-PTSD)
  - PTSD Checklist (17 items; Civilian, Military, and Stressor Specific versions)
- Psychotherapy Interventions for Treatment of PTSD
  - Trauma-focused psychotherapies – significant benefit
    - Exposure and/or cognitive restructuring (prolonged exposure (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR))
  - Stress Inoculation Training – significant benefit
  - Patient education, imagery rehearsal therapy, psychodynamic therapy, hypnosis, relaxation techniques, group therapy – some benefit

# VA/DoD Clinical Practice Guidelines

## *Management of Substance Use Disorders*

<http://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf>

### – Screening

- Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)
  - How often did you have a drink containing alcohol in the past year?
  - On days in the past year when you drank alcohol how many drinks did you typically drink?
  - How often did you have 6 or more drinks on an occasion in the past year?
- Single Item Alcohol Screening Questionnaire (SASQ)
  - Do you sometimes drink beer, wine, or other alcoholic beverages?
  - Followed by screening question: How many times in the past year have you had...
    - » Men: 5 or more drinks in a day
    - » Women: 4 or more drinks in a day

### – Psychosocial Interventions

- Brief Alcohol Intervention
  - Recommended for adults who screen positive for unhealthy alcohol use (Women = AUDIT-C score  $\geq 3$ ; Men = AUDIT-C score  $\geq 4$ )
  - Psychoeducation intervention focusing on alcohol-related risks and advice to abstain from unhealthy drinking
- Cognitive Behavioral Therapy
  - Focuses on the modification of thinking and behaviors related to alcohol use, and to change life circumstances that facilitates or encourages alcohol use

# PTSD Treatment

## Cognitive Processing Therapy (CPT)

- Best-practice model for PTSD in adults per the *International Society for Traumatic Stress Studies Practice Guideline*
- Individual and group settings or a combination of both
- 12 sessions, with a recommended follow-up session 1 month later
  - Phase 1: Analyze, gather information, and identify feelings (sessions 1 - 5)
  - Phase 2: Challenge (sessions 5 -7)
  - Phase 3: Change (sessions 7 -12)

# PTSD Treatment

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## Prolonged Exposure (PE)

- Addresses fear that activates “fight or flight” response
- PTSD patients overgeneralize this fear response to the extent that they avoid or escape situations that are not dangerous
- 10 to 12 90-minute individual treatment sessions conducted once or twice weekly
- Four Primary Components
  - Repeated revisiting of the trauma memories
  - Repeated exposure to avoided situation
  - Education about common reactions to trauma
  - Breathing retraining

# SUD Treatment

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## Cognitive Behavioral Therapy

- Structured, short-term, present-oriented psychotherapy
  - 6 to 14 sessions
  - Weekly therapy sessions
  - “booster” sessions (every 3 months annually)
- Focused on abstinence or reducing substance use and modifying dysfunctional thinking and behavior related to substance use
- Relapse prevention focuses on life circumstances that may facilitate or encourage substance use

# PTSD & SUD Treatment Targeting Women

## Seeking Safety (SS)

- Cognitive behavioral therapy originally developed to treat co-occurring PTSD and substance use disorder in women
- Currently implemented in individual and group modalities for both men and women in same-sex and coed groups in inpatient and outpatient settings
- Manualized treatment that addressed 25 topics within 4 domains
  - Cognitive
  - Behavioral
  - Interpersonal
  - Case management
- Not included as a recommendation in VA/DoD Clinical Practice Guidelines

# Thank You

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