Questions Asked During Live Webinar Broadcast on 8/24/19

Supporting Those Who Served: Substance Use and Comprehensive Mental Health for Military Affiliated Populations

Presenter: Duane K. L. France, MA, MBA, LPC

Isn't it dangerous to be pushing EMDR when PE is clearly the frontline treatment for PTSD?

A: I personally believe that it would benefit the client to have the treatment that works best for them. Here is a direct quote from the recently released VA/DOD Clinical Practice Guidelines for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder:

> *For patients with PTSD, we recommend individual, manualized trauma- focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.*

As can be seen, EMDR is listed as a recommended intervention along with Prolonged Exposure and a number of others. I believe that it's important to prepare clients for these types of interventions and maintain association with colleagues who are certified in other interventions in order to best meet the needs and responsiveness of the service member, veteran, or military family member.

IN this webinar you are using the term Addiction. In my opinion differentiation should be emphasized between addiction and SUD. Are you implying they are the same?

A: Great question, and there is certainly a distinction between addiction and substance use disorders. There is certainly no implication that they are the same. Substance use disorders are clinical diagnoses according the Diagnostic and Statistics Manual, while addiction is applied to an individual's compulsive use of a particular substance, thing, or activity. As mentioned in the webinar, there are process addictions that the military affiliated population experience that go beyond substance use, and therefore substance use disorders. The broader category is inclusive of NAADAC's commitment to all addiction professionals, not just substance use disorder treatment providers.

Is ECT ever utilized?

A: Electroconvulsive therapy is a medical procedure that is often used for extreme cases of medication-resistant depression. While effective, the side effects are significant and it's an invasive procedure. An emerging alternative is Transcranial Magnetic Stimulation, which is less intrusive and has shown benefits. It is currently FDA approved to treat medication-resistant depression, but current studies are underway to determine the benefit to alleviating symptoms of PTSD and other trauma-related disorders.

What's your take on Medicinal Marijuana?

A: I recognize that many veterans indicate that it provides relief from chronic pain, reduces anxiety symptoms, and provides relief from hypervigilance. I believe that there is some benefit from cannabidiols, but there has not yet been the ability to fully remove THC from CBDs.

Personally, I am generally not in favor of using anything external to us to do what we can do for ourselves: regulate emotion, reduce symptoms, and control behavior. This is not solely limited to medicinal marijuana; I feel that it is more beneficial for a client to manage their symptoms without medication of any kind or relying on an external source for comfort or relief. That's not to say that medication is not beneficial, and that a combination of therapy and medication may be what's best for the client. But relying on an external source to do for us what we can do for ourselves means that we are not learning coping techniques that helps us regulate when that external source is not available to us.

I do believe that there needs to be more research into the benefits of CBD for symptom relief, which is limited by the current federal regulations. If we can provide the beneficial effects of medicinal marijuana without the harmful effects, then that would be best.

Does the military use EMDR? If so, do you think if EMDR is used early on that one's addictive behavior can be avoided to some degree since they are not needing to self-medicate as much since the replay of the PTSD isn't going on as loudly in the frontal lobe?

A: As previously identified, the joint VA/DOD clinical practice guidelines do list EMDR as a primary intervention for PTSD. And using interventions that alleviate symptoms of PTSD can certainly lead to reduced reliance on substances to manage those symptoms. As identified in the webinar, however, the true underlying cause of the client's symptoms must be identified, because EMDR and exposure therapies are beneficial for processing traumatic events, but other interventions are indicated for anxiety, depression, a lack of purpose and meaning, etc. Substance use may be tied to symptom relief in these other conditions, rather than just PTSD.

Nowadays more and more military members may experience combat without experiencing traditional combat. Should we consider anything unique when providing counseling services or recovery support for a vet who was involved in drone strikes and presents with PTSD symptoms?

A: I think the primary thing is to begin working with clients without any preconceived notions about the nature of their trauma. Regardless of where or how the client experienced trauma, clinicians must understand that the client's subjective response is important consider. As identified in this article from 2014, there is not enough research on the psychological impact of remote combat, but indications are that it impacts some service members and veterans adversely.

You mentioned Martin Seligman earlier, was that the positive psychology guy? Can you say more about his affiliation and work with military and veteran culture?

A: I did mention Dr. Seligman; I did not intend to imply that he has expressly applied his concepts to military and veteran culture, any more than Frankl and Yalom have. Dr. Seligman and his team at the Positive Psychology Center at UPenn have provided resilience training for the United States Army, but I was simply referring to how to apply his concept of learned helplessness to the military experience.

Have you written any books on today's topic where we can learn more about military and veteran culture?

A: I have not yet written any books covering the comprehensive veteran mental health model; I have been in discussion with editors in the past, but it is a work in progress. I have written about this topic extensively on my blog; relevant links can be found on the webinar notes page.

Can a family member of a vet experience PTSD from hearing about their loved one's story, maybe the loved one was overseas and described an event in great detail over the phone and it traumatized the spouse? How can we help them?

A: As we know as clinicians, vicarious trauma is possible when hearing repeated descriptions of trauma. Additionally, Criterion A for PTSD is: "The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):"

- Direct exposure
- Witnessing the trauma
- ***Learning that a relative or close friend was exposed to a trauma***
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

So, it is likely that hearing of a traumatic event in detail by a loved one could possibly result in traumatic stress reaction, which left unresolved can develop into PTSD. More likely, however, is the ambiguity that is associated with sharing traumatic events; in my personal experience, a veteran will not likely share the details of the traumatic event(s) even with those closest to them.

Helping the family member with vicarious trauma is the same as helping the veteran themselves with primary trauma, using evidence based treatments to resolve the traumatic stress reaction. Additional support may be needed to help understand the changes that have occurred in each family member individually and the family unit as a whole.

What are the most prevalent and dangerous substances used by vets or military members who also have PTSD?

A: The first substances that come to mind, for me personally, are alcohol, opiates in various forms, and methamphetamines. An article on the prevalence of substance use disorders in the military population identify the most commonly abused substances are alcohol, prescription drugs to include opiates, and marijuana. Nicotine dependence is also identified as a significant issue. I'm describing the intent of the use, to the point of dependence based on alleviation of symptoms, rather than the use itself. Alcohol use, smoking, prescription medication use, and marijuana use (in some locations) is not illegal or illicit; instead, it is the reason behind *why* the service member or veteran is using the substance, and the frequency and quantity of use, that must be addressed.