



*Promoting equity in engagement, access, and quality of mental health care for Veterans facing barriers to care, especially rural Veterans*

August 2013 Vol 15, Issue 8

www.mirecc.va.gov/visn16

# Communiqué

## In This Issue

OKC Site Leader, Dr. Thomas Teasdale, Retires from the VA	p. 1
Research to Practice: Talking with Veterans about Sexual Health Issues	p. 1
August CBOC MH Rounds: Mobile Apps for MH	p. 3
Recent SC MIRECC Publications	p. 5

### South Central MIRECC Anchor Sites:

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**Patricia Dubbert, Ph.D.**  
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*Associate Director for Improving Clinical Care*

## Dr. Thomas Teasdale, SC MIRECC Oklahoma City Site Leader, Retiring from the VA

Interviewed by Ashley McDaniel

*Q. Tell us about your career. When did you join the VA and at what universities have you worked?*

I began working at the Houston VA Medical Center in August 1983. Time flies! It's been 30 years. The position was a half-time research assistant for the (then) Chief of Medicine, Dr. Robert J. Luchi. I was in charge of monitoring a Hewlett Packard EKG interpreting computer used in a cardiology research project. The two 5 megabyte disk drives were each almost the size of a washing machine. When the Chief of Medicine transitioned to the Associate Chief of Staff for Geriatrics and Extended Care, my role shifted to Health Services Specialist and my attention focused on the older Veteran.



*Thomas Teasdale, Dr.P.H.*

See TEASDALE on page 2

## RESEARCH TO PRACTICE

### Talking with Veterans about Sexual Health Issues

Summary by Patricia Dubbert, PhD

Two recent articles provide useful suggestions for talking with patients about sexual health problems and military sexual trauma. Many patients and providers are uncomfortable discussing these issues, but they may be extremely important to the patient's well-being. The first article, from the *Journal of Sexual Medicine*, describes a study by a group of VA investigators including SC



See PRACTICE on page 4

## TEASDALE (continued from page 1)

My academic home was in the Huffington Center on Aging at Baylor College of Medicine (BCM) where I worked as an instructor and assistant professor helping write grants and train medical students, residents, physician assistants, and geriatric fellows. It was easy to complete my master's and doctoral degrees over the next few years from that very fertile, dual environment of VA and BCM. I remained nearly full-time VA for almost 20 years.

In 2003, I accepted the position of Director of Research with the Donald W. Reynolds Department of Geriatric Medicine at the University of Oklahoma Health Sciences Center. The focus was on clinical and health services research, but in a wonderful twist of fate, my greatest success over the next few years was to build a very strong basic science research component in the Department. The recruited director of that component took over the research director role and I was free to become the department's Director of Education, a much better fit. I also took on directorship of the Oklahoma Geriatric Education Center and have been twice successful in renewing its federal funding. More recently, I became the vice chairman of the department, primarily for education activities.

*Q. You've served as a MIRECC site leader for many years. Please tell us a little about your work during this time.*

Some of my most exciting times at the Houston VA Medical Center and BCM involved interacting with a new physician, Dr. Mark Kunik. As a gero-psychiatrist, he energized many community stakeholders and faculty members in ways not previously possible. While the geriatrics approach to patient care fit well with my public health training and appreciation of older individuals, the mental health providers who I met through Dr. Kunik appeared to be doing tremendous good through psychiatry and psychology. In short order, I

learned that it's always rewarding to work with Mark. In turn, Dr. Kunik introduced me to the still somewhat new SC MIRECC. Luckily, I was successful in competing for and completing Clinical Educator Grants, which gave me slightly more visibility within the SC MIRECC.

My move to Oklahoma City opened a door for additional SC MIRECC support to be located at the Oklahoma City VA Medical Center and SC MIRECC leadership was willing to further invest in the good work being conducted here by long-term SC MIRECC investigators.

Formally establishing anchor site leaders within the virtual SC MIRECC was a brilliant decision by leadership that resulted in the SC MIRECC having a place at the table within local mental health services. My being named the Oklahoma City Anchor Site Leader was a great honor that had a side effect of freeing very productive others from the administrative chores that come with site designation.

*Q. What have been the biggest changes in your field during your career? How has your career evolved because of those changes?*

Monumental changes in VA were implemented by Dr. Kenneth Kizer in the 1990s. In my opinion, many of those changes helped position VA as America's leader in the provision of high quality health care. Some changes took longer than others to implement, but certainly, we have a much improved environment of care (e.g., CPRS electronic medical record) and focused attention on improving care to subgroups of Veterans (e.g., those with mental illness, specialized rehabilitation potential, and women).

However, the largest change might be the shift from being in VA Geriatrics Service thinking about mental health issues (1983-2003) to being in SC MIRECC/Mental Health Service with a continuing eye on older Veterans (2003-2013).

### ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

continued on page 3

continued from page 2

*Q. What have you enjoyed the most about your work?*

It sounds simple, but I enjoy working with others. VA allowed me to be a part of something very big; so big that there are usually teams of people working together to solve problems and improve quality of life. I have relished that and I am honored to have worked alongside so many superb colleagues.

*Q. What will you do when you retire?*

I'm not fully retiring. I'm simply retiring from VA employment. Starting September 1, my full week will now be "owned" by the university rather than being split by VA and university. I will continue as professor and vice chairman in the geriatrics department, director of the Oklahoma Geriatric Education Center, associate director of the Oklahoma Healthy Aging Initiative, director/co-director for several medical school courses, faculty sponsor for campus-wide student interest groups, and contributor to numerous local, state, and national committees. Anyone who wants to "retire" with me is welcome to come aboard.

*Q. Anything else you want to share with our readers?*

It would be wonderful to think that everyone who should receive that big "Thank You" from me actually feels it. My hope is that I have helped at least as many people as have helped me. If approved, I will have a without compensation appointment with Oklahoma City VA Medical Center Mental Health Service when my paid service ends. I just can't imagine not formally contributing to the wellbeing of Veterans with my good colleagues at the VA who do the valuable work of the SC MIRECC. ♦

# CBOC Mental Health Rounds

2nd Wednesdays Monthly  
8:00-9:00 AM CT  
1-800-767-1750; 26461#

*Sponsored by the South Central MIRECC*

VA Mental health providers are invited to attend the next CBOC Mental Health Rounds session titled "Mobile Applications for Mental Health" on Wednesday, August 14 at 8:00-9:00 a.m. (CT). This Microsoft Lync session will be presented by Julia Hoffman, PsyD. At the conclusion of this educational program, learners will be able to:

1. Recognize why and when mobile applications may be a valuable supplement to existing mechanisms;
2. Identify existing mobile application resources that can be used with Veterans and their basic features and functions; and
3. Locate resources for obtaining mobile applications for use with patients.

Call 1-800-767-1750 and use access code 26461# to participate. Email [Ashley.McDaniel@va.gov](mailto:Ashley.McDaniel@va.gov) or call (501) 257-1223 for registration and continuing education credit information.

## PRACTICE (continued from page 1)

MIRECC's Michael Kauth and others from the Michael E. DeBakey VA Medical Center in Houston. The research team examined comments regarding sexual health issues from medical record notes for initial visits and six month follow-up visits for new patients seen in a VAMC post-deployment clinic.

The majority of the 158 patients were male (87%) and heterosexual (94%). Only two patients reported military sexual trauma, but almost 25% of the patients reported at least one sexual problem. More than 50 different sexual health issues were identified; the most common were low libido, erectile dysfunction, sexual abuse, and sexually transmitted diseases. Sexual problems were most often documented in follow-up visits, by mental health providers, and when templates were used that prompted the clinician to ask about sexual issues. When noted in an initial visit, problems were often not followed up in later visits.

The researchers concluded that templates probably helped providers document sexual problems, especially in initial visits, but failure to follow up could discourage patients from getting adequate treatment. Using templates and prompting providers to address sexual issues at follow-up visits may be a more favorable combination. This would allow time for patients to become more comfortable with their providers, and help providers remember to initiate inquiry if patients have not mentioned sexual concerns.

In the second article, VA investigators used semi-structured interviews to understand barriers to care for male Veterans who had reported military sexual trauma (MST) but had not sought any mental health treatment. The research team, led by Jessica Turchik at the Palo Alto VA Medical Center, published their study in a recent issue of *Psychological Services*. The article includes many quotes from the interviews that help readers to appreciate the concerns of Veterans that might prevent them from seeking treatment for MST.

Stigma was a major concern, and seemed directly related to the sexual nature of the trauma and not to seeking help in general. Self-blame was another issue, with some Veterans reporting that they felt they had provoked or allowed the assault; some felt that unless the event was violent, others would not feel it was important or serious enough to need treatment. The Veterans' responses also underscored the importance of providers' reactions to patients' reports of MST. They often expected providers to try to avoid the topic, or if they had to talk about it, anticipated providers would

be disgusted, blame the patient, or not believe the patient's story. Surprisingly, many did not know that VA has specific services for male as well as female Veterans who have experienced MST. About 50% of these male MST patients said they would prefer a female provider, 25% preferred a male, and 25% had no preference.

The study results confirmed some previous research about the important roles of stigma, self-blame, shame, and fears as barriers to seeking treatment for MST, and showed that these issues are prominent for male as well as female victims. The results suggest that advertising about treatment for MST needs to show both male and female Veterans can receive services. Providers need to be very sensitive in exploring MST concerns and respect Veterans' provider gender preferences when possible to help reduce communication barriers.

To view these articles, visit <http://www.ncbi.nlm.nih.gov/pubmed>.

### Citations

- Helmer, D. A., Beaulieu, G. R., Houlette, C., Latini, D., Goltz, H. H., Etienne, S., & Kauth, M. (2013). Assessment and documentation of sexual health issues of recent combat Veterans seeking VHA care. *The Journal of Sexual Medicine, 10*(4), 1065-1073.
- Turchik, J. A., McLean, C., Rafie, S., Hoyt, T., Rosen, C. S., & Kimerling, R. (2013). Perceived barriers to care and provider gender preferences among Veteran men who have experienced military sexual trauma: A qualitative analysis. *Psychological Services, 10*(2), 213-222. ♦

### **Upcoming CBOC Mental Health Rounds Second Wednesdays Monthly 8:00-9:00 am CT; (800) 767-1750; 26461#**

August 14, 2013  
*Safety Planning App*

September 11, 2013  
*Interventions for Aggression in Dementia*

October 9, 2013  
*Neuropsychiatric Side Effects of Medication*

November 13, 2013  
*Gun Safety*

## RECENT SC MIRECC PUBLICATIONS

### **PREDICTORS OF TREATMENT SATISFACTION AMONG OLDER ADULTS WITH ANXIETY IN A PRIMARY CARE PSYCHOLOGY PROGRAM**

**Hundt NE, Armento ME, Porter B, Cully JA, Kunik ME, Stanley M**

*Evaluation and Program Planning, April 2013, 37, 58-63*

Increasing numbers of patients are treated in integrated primary care mental health programs. This study examined predictors of satisfaction with treatment in patients from a randomized clinical trial of late-life generalized anxiety disorder in primary care. Higher treatment satisfaction was associated with receiving cognitive behavioral therapy (CBT) rather than enhanced usual care. Treatment credibility, treatment expectancies, social support, and improvements in depression and anxiety symptoms predicted higher treatment satisfaction in the total sample. In the CBT group, only credibility and adherence with treatment predicted satisfaction. This suggests that older patients receiving CBT who believe more strongly in the treatment rationale and follow the therapist's recommendations more closely are likely to report satisfaction at the end of treatment. In addition, this study found that adherence mediated the relationship between treatment credibility and treatment satisfaction. In other words, patients' perceptions that the treatment made sense for them led to greater treatment adherence, which then increased their satisfaction with treatment.

### **SECONDARY PSYCHOPATHY, BUT NOT PRIMARY PSYCHOPATHY, IS ASSOCIATED WITH RISKY DECISION-MAKING IN NONINSTITUTIONALIZED YOUNG ADULTS**

**Dean AC, Altstein LL, Berman ME, Constans JI, Sugar CA, McCloskey MS**

*Personality and Individual Differences, January 2013, 54(2), 272-277*

Although risky decision-making has been posited to contribute to the maladaptive behavior of individuals with psychopathic tendencies, the performance of psychopathic groups on a common task of risky decision-making, the

Iowa Gambling Task (Bechara, Damasio, Damasio, & Anderson, 1994), has been equivocal. Different aspects of psychopathy (personality traits, antisocial deviance) and/or moderating variables may help to explain these inconsistent findings. In a sample of college students (N = 129, age 18 to 27), we examined the relationship between primary and secondary psychopathic features and Iowa Gambling Task performance. A measure of impulsivity was included to investigate its potential as a moderator. In a joint model including main effects and interactions between primary psychopathy, secondary psychopathy and impulsivity, only secondary psychopathy was significantly related to risky Iowa Gambling Task performance, and this effect was not moderated by the other variables. This finding supports the growing literature suggesting that secondary psychopathy is a better predictor of decision-making problems than the primary psychopathic personality traits of lack of empathy and remorselessness.

### **STIGMA ASSOCIATED WITH PTSD: PERCEPTIONS OF TREATMENT-SEEKING COMBAT VETERANS**

**Mittal D, Drummond KL, Blevins D, Curran G, Corrigan P, Sullivan G**

*Psychiatric Rehabilitation Journal, June 2013, 36(2), 86-92*

Although stigma associated with serious mental illness, substance abuse disorders, and depression has been studied, very little is known about stigma associated with PTSD. This study explored stigma related to PTSD among treatment-seeking Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) combat Veterans. Sixteen treatment-seeking OEF/OIF Veterans with combat-related PTSD participated in focus groups. We used qualitative methods to explore PTSD-related stigma. Results showed that common perceived stereotypes of treatment-seeking Veterans with PTSD included labels such as "dangerous/violent," or "crazy," and a belief that combat Veterans are responsible for having PTSD. Most participants reported avoiding treatment early on to circumvent a label of mental illness. Participants initially reported experiencing some degree of self-stigma; however, following engagement in treatment they

**continued on page 6**

**continued from page 5**

predominantly resisted these stereotypes. Although most participants considered combat-related PTSD as less stigmatizing than other mental illnesses, they reported difficulties with reintegration. Such challenges likely stem both from PTSD symptoms and Veterans' perceptions of how the public views them. Most reported that fellow combat Veterans understood them best. We conclude that awareness of public stereotypes impacts help seeking at least early in the course of illness. We find that peer-based outreach and therapy groups may help Veterans engage in treatment early and resist stigma. ♦

Published by the South Central MIRECC  
Editor: Ashley McDaniel, M.A.  
Reviewer: Carrie Edlund, M.S., M.A.

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