National VA Mental Health Wellness & Recovery Webinar Series:

Promoting Recovery, Resilience and Suicide Prevention with Holistic and Spiritually Integrated Treatments: Taking Care of Our Veterans and Ourselves

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Dr. Samantha Hack: VISN 5 Mental Illness Research, Education and Clinical Center, or MIRECC, in partnership with the Employee Education System. The planning committee members for this Webinar series include Daniel Bradford, Valerie Fox, Spencer Glipa, Catherine Lewis, Marty Oexner, Kathryn Peacock-Dutt, Donna Russo, Tim Smith, my co-host Ralf Schneider and myself Samantha Hack. Today's Webinar is entitled, 'Promoting Recovery, Resilience, and Suicide Prevention with Holistic and Spiritually Integrated Treatment - Taking care of Our Veterans and Ourselves'. Our presenter for today's Webinar is Dr. Donna Ames. Donna Ames is a staff psychiatrist at the Greater Los Angeles VA Healthcare System, and a Professor of Psychiatry and Residence at the University of California at Los Angeles' David Geffen School of Medicine. Her research career spans four decades, since she was an undergraduate in college. Her research has focused on optimizing the clinical care of people with serious mental illness, utilizing a holistic recovery-oriented bio-psycho-social-spiritual approach. She served for ten years as a PRRC program leader and five years as an unofficial local recovery coordinator until 2017. She was involved in the system's redesign to convert day treatment and day hospital programs to PRRC. Prior to that, she had twenty years of inpatient and outpatient experience, and she is now working in the general mental health clinic at Greater Los Angeles VAMC, where she continues her efforts to promote recovery-oriented care. She has received grant funding for her research from the VA Merit Review Program and private foundation. She has presented nationally and internationally and she and her research team have over 100 publications in the field. Most importantly, Dr. Ames is a daughter, wife, mother, sister, aunt and granddaughter. Before I turn it over to Dr. Ames, I will mention that she has reserved time for questions at the end of the presentation, but if she does not get to your question, you can E-mail her, she will provide her E-mail at the end. So at this time I'm happy to turn the Webinar over to you Dr. Ames.

Dr. Donna Ames: Thank you so much for that introduction. I'll add to the list, one of my joyful, um, things that I do, is I'm a grandmother too. That is really a joy in my life. So, I'm really excited to be here to talk about this subject and hope that this will be helpful to you and that you could avail yourselves to me through E-mails as Samantha mentioned, if we don't get enough time for questions. This is my disclaimer slide. So, I wanted to begin the talk by thinking about why we're all here today and what it is that we're doing and this noble effort that we are here in the honor we have to help with preventing suicide and helping promote recovery amongst our Veterans. This is a picture from a movie that came out about the high rates of suicide amongst Veterans. And I met one of the young men on the motorcycles here, because his friend was going to kill himself. He put a gun to his head and then he reached out to his peers, to his friend, and he did not commit suicide, and they went on a motorcycle journey across the country to raise awareness for the high rates of Veteran suicide. At the time it was 22 Veterans committing suicide in 2013, and they went throughout the country to look at the different ways that Veterans were recovering from post-traumatic stress disorder in particular. It's a wonderful movie if you get a chance to watch it, and incredibly powerful. You can download it from, I think it's on Public Television. So, my impression is that there is still a need for better treatment to offer greater hope of recovery for Veterans. With the case of post-traumatic stress disorder, medications are not necessarily the go to treatment, and sometimes these evidence-based treatments are not necessarily acceptable to all Veterans. So, the VA has mandated the recovery model for serious mental illness, and it's different than a medical model, it's patient- centered, and it includes a holistic approach, it is multidisciplinary. Recovery embraces the notion that people with serious mental illness can live a meaningful life and happiness is a byproduct of living a meaningful life. Viktor Frankl, Man's Search for Meaning is a great resource, this, um, psychiatrist, who survived Auschwitz, and his approach to helping people with recovery from post-traumatic stress. Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full

potential. I love that. I love that mental health recovery can help heal and transform people. And in my years of working at the VA I've seen these wonderful recovery stories happen. This is from the most recent Veteran Suicide Prevention Annual Report, November 2020, and it shows the different rates of suicide amongst Veterans and we see here that the blue line is the youngest group of people with the increased rate of suicide over the years 2005 to 2018. Each of these different age groups are characterized here. I wanted to show this slide, because as I think about a holistic approach that is bio-psycho-social and spiritual for the treatment of mental illness. I wanted to show this next slide, this is from the Acute Research Center about religious practice amongst millennials. This is a bit of an old slide from 2010, showing the attendance at religious services by generation, and I thought about this, the fact that only 18% of millennials reported going to any type of religious service in 2010. You see the other generations, the higher rates of religious service attendance. And again, looking at the suicide risk here, and increased suicide rates in our younger folks. This is an article that came out December 2020 about healthcare providers, and there were about 40,000 male participants and over 66,000 female healthcare providers in this study. The authors looked at religious service attendance and deaths related to drug, alcohol and suicide, and they found that religious service attendance was protective against these deaths from despair. So, again, my thought is as we work, we work with Veterans, the recovery model embraces holistic, which is biological, psychological, social, and spiritual. And when we work with Veterans that we have a multidisciplinary team that can approach and help them from these different aspects, including chaplains as well in the spiritual part. So, one of the things that we are doing with Veterans in looking at ourselves, is what we must realize is that our Veterans and we, as healthcare providers, are very resilient. And one of the things we are doing when we approach Veterans, is asking them what their strengths are. What makes them strong? What helps them to bounce back and rebound? Resilience comes from that word, resilio. And, our Veterans and ourselves, have a lot of perseverance and passion, and I think one thing that when I talk to Veterans and when I think about ourselves is that we have to be gentle with ourselves and realize

that some of the things that we've all gone through have made us more beautiful by our imperfections. Wabi Sabi is a Japanese term that is related to a Japanese art, where if a pot had a crack in it they put a piece of gold in it to make it more beautiful. And that's how our Veterans are, and that's how we are. We are all made better by the things that we've gone through, and I like that my slide has this little N to show that I'm not perfect (laughter), I typed my slide. So, um, resilient people have intrinsic factors that cause them to be resilient, they have positive attitude, optimism, ability to emotionally self-regulate, and see problems and failures as learning experiences. Extrinsic factors also play a part in resilience. Social and environmental support can help people with their resilience. So, for many of us in the healthcare profession, we've had to endure a lot of training, a lot of struggles, many have endured partaking on a lot of financial support, financial debt. So, we are resilient and we're hardworking. This is a scale that measures resilience that you can use to look at yourself, as well as to look at your Veterans. It's a very brief scale. I like brief scales. So, it has some pretty quick questions to ask about resilience, such as "I tend to bounce back quickly after hard times", "It does not take me long to recover from a stressful event". Some questions that are raised to be scored in the reverse. Although resilient, what many mental healthcare providers can develop for burnout, depression, moral injury, which I will be talking more about, and substance abuse. The pandemic has been adding to increasing stress, um, acute, and even post-traumatic stress symptoms in healthcare providers. And, of course, by the way we're seeing more and more increases in depression and symptoms in our patients due to the pandemic as well. The loneliness, the isolation, adding to their struggle. This was a presentation at the APA meeting, American Psychiatric Association meeting in 2018, showing that male physicians were at a 40% higher risk than other U.S. males for suicide, and female physicians at 130% higher suicide risk. When this slide was made, it is estimated that Veterans were killing themselves at a rate of 20 per day in our country, and physicians are killing themselves at 1 per day in our country. I think this is a very serious problem and that's why we're here, because I think we have to take care of ourselves. In an emergency, you have to take care of yourself, if you're on an airplane,

you gotta pull the air bag down, take deep breath, and then you help your child; and it's the same for healthcare providers with our Veterans. We must take care of ourselves. Burnout is actually very toxic and costly and it's an ICD-9 Code QD85, resulting from chronic workplace stress. Burnout can cause people to have a lack of empathy and cynicism and impaired job performance and impaired relations with family and friends. One thing that is often cited is the electronic health record is invading the home. Physician burnout is considered a public health crisis, unintentional accidents of billions of dollars of cost due to medical errors. Burnout is also considered a loss of motivation. So, when we do think we have intrinsic motivation or extrinsic motivation, we do things because we find them interesting or we have a passion for it – that's our intrinsic motivation. Our extrinsic motivation are things like positive or negative, and so it's interesting that paradoxically monetary reward can undermine intrinsic motivation. However, the best extrinsic motivators for, are annual pay raises, or annual bonuses, but when money is brought into the floor, with each patient interaction, RVU's, it decreases intrinsic motivation. Burnout in clinicians and MDs is related to lack of control over one's schedule, not even being able to control the language used in charting, and according to Hartzbrand and Groopman, in their recent New England Journal of Medicine article, every hour of patient time is met with two hours of computer time. So burnout symptoms can be thought of as, like reductions in energy account; you feel exhausted, you're depersonalized, you lose physical energy, emotional energy, lack of efficacy or spiritual energy. Sometimes burnout is referred as compassion fatigue.

In a survey of 15,000 doctors, they estimated 44% were burned out, 11% colloquially clinically depressed. In the same survey, 25% of physicians reported having thoughts of suicide. Burnout in therapists has been looked at as well, American Psychological Association 2018 estimated 21 to 61% of mental health providers are burnout. In a review paper, 9,000 therapists across a bunch of studies, they estimated 50% suffered from burnout. So, in a Medscape National Survey, the one with 15,000 doctors, it was estimated that 39% of psychiatrists were burned out. The highest burnout

level was seen in Urology, Neurology, and physical medicine and rehab. And these are things that doctors mentioned more the things that contributed to most of their burnout. Too many bureaucratic tasks, spending too many hours at work, increased computerization of practice, lack of respect, insufficient compensation and reimbursement, lack of control or autonomy, government regulations, feeling like just a cog in a wheel, emphasis on profits over patients and lack of respect from patients. So these are the things that can contribute to a clinician's sense of feeling overwhelmed, or burned out, family responsibilities, time pressure, chaotic environment, low control of pace, and of course the electronic health records, which was originally set up to help clinicians, is actually deemed to be a slave master to clinicians in many ways. So, there are three pillars that prevent burnout. Autonomy, competence, and relatedness. By autonomy it means having more control over the time that you want to spend with your patient. Flexible scheduling. Clinicians and patients as individuals. Flexible scheduling allows clinicians to optimize the relatedness to their patients, as opposed to their relatedness to the electronic health record. And one thing that is thought that might help to start reducing burnout is purging the system of meaningless metrics and really relatedness should be authentic and needs to adopt to the clinician and the patient's needs. Again, this comes from Hartzbrand and Groopman, New England Journal of Medicine. As I thought about ways that we can help ourselves with preventing burnout, and improving our energy, these are some tips, and after thirty years of working at the VA I wish I had taken some of these tips earlier in my career, and so if there is folks new in the profession, I hope you really think about these things because you want to maintain your energy. You want to be the best you can be with your Veteran, though end your workday at the end of the payday. Take your lunch, your rest daily. Take every earned vacation day every year. Take at least one day off a month to recharge. Take a complete electronic Sabbath one day a week. Don't look at you're EHR at the end of the workday or work E-mail. Lean into your relationships with the people you love, and work on your own recovery plan. So, make sure that you're always focusing on what you want to do with your life. And so, when I worked at the PRRC I worked with Tom Fletcher, and Rick Martin,

local recovery coordinators, who developed this My Personal Recovery Plan, and I think that this is a wonderful plan because I really also see recovery planning as suicide prevention planning. So, when we get Veterans who worked on their vision of recovery, when we work on our visions of recovery, this is really positive behavior. We work on folks' strengths. I remember when I started doing the recovery plans with Veterans, I would ask somebody with a serious mental illness, somebody say with schizophrenia, what are your strengths? And they were always shocked, like, "Nobody's ever asked me what my strengths are." So, what I love about the recovery model is that we really are looking our Veterans for their strengths, for what they want. And this is what we're doing with the My Personal Recovery Plan. And, in helping them envision their lives and move forward on their goals. So, as a psychiatrist, I can say, when I first started my career I was very much interested in psychopharmacology and treating people with schizophrenia was my goal and I, over my 30-year career, realized it's not just psychopharmacology that helps people. And as a matter of fact, Thomas Edison said the doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame and a proper diet, and in the cause and prevention of disease. So one of the things I noticed over the course of working with Veterans and treating them with antipsychotic medications, was tremendous weight gain, diabetes, and other metabolic problems from taking antipsychotic medication. So, for ten years I did research on developing a program that would help Veterans lose weight and focus a lot on exercise and nutrition with Veterans with serious mental illness, and we had really good results. But after ten years of studying exercise and nutrition, I thought, it's more than this. There's more things we can do to help Veterans. And Roger Walsh suggested that there is therapeutic lifestyle changes, exercise, nutrition and diet, time and nature, recreation, relaxation, stress management, religious and spiritual involvement, community involvement or volunteerism, that all psychiatrists should be prescribing to their Veterans. That there's evidence for these eight things to really help our Veterans. And so, after reading his article, we developed a little research study, and in my clinical practice we started to ask Veterans to come up with a TLC diary, a therapeutic lifestyle practice

diary. Yeah, I think this is part of suicide prevention. Working on these different eight things, and it's remarkable how well our Veterans can do. We don't want to overwhelm them, but we can start with one or two things, but we developed a workbook for TLC's that a clinician can work with a Veteran and coach them on developing goals in these areas. Again, exercise, nutrition and diet, time and nature, relationships, recreation, relaxation, stress management, religious or spiritual involvement and service in helping others. So, you can make smart goals for these TLC's – specific, measurable, attainable, realistic and time-bound. So, if you want these materials we have the diaries, we have workbooks, we have a TLC training manual, and TLC single worksheets. In my practice now, in the outpatient mental health clinic, I still use the TLCs, I still use the recovery plan, and I have also really continued to train nurses who work in my clinic, to work with Veterans on these things. So, this is an article that we published on TLC's and how it helps Veterans with weight and quality of life and psychiatric symptoms. This is our cover of our little workbook, so feel free to E-mail me – we can send you this material, I can provide anymore information your would like. If you would like to integrate this into your program. Along my paths and journey, I have had the privilege when I was working in a PRRC, to work with Chaplain Sam Adamson, and he introduced me to a researcher who was interested in studying moral injury in Veterans. The researcher is Dr. Harold Koenig, whose expertise is in religion and health, religion and mental health. And so, one of the things he developed was this model, moral injury, and I want to mention that moral injury can impact not only Veterans not only combat Veterans or non-combat Veterans, but also civilians, and it can impact us. Um, and this, we started this research I think in about 2016 and, um, based on this model, that there are events in our lives where, um, and in the lives of our Veterans, which may lead to a moral injury or inter-conflict in mental health outcome. So, such event as killing, violence to others, witnessing violence, not protecting, put in morally compromising positions – not protecting is something that resonates with me, as a mom, or as a clinician. If something happens to one of my Veterans, I feel, I may feel like what did I do wrong? What could I have done better to protect that Veteran? So, Dr. Koenig has now

developed a scale to measure moral injury in clinicians. We worked together for several years to develop a scale for combat Veterans. And so these are the symptoms of moral injury: guilt, shame, self-condemnation in his model, feelings of betrayal, difficulty forgiving, loss of trust, meaning, hope, spiritual struggles, loss of faith. And then mental health outcomes could be PTSD symptoms, depression, anxiety, substance abuse, sleep problems, relationship dysfunction and pain issues. I know sometimes I just show this little slide to my Veterans who walk into my office who have not responded to conventional treatment for post-traumatic stress disorder, or substance abuse issues, or chronic anger issues. I feel like moral injury is one of the emotions that really resonates with folks who have this is anger. So, when I show this little graph to folks they go, "That's me. That's what happened. I was in combat and I didn't do this, or I did that". And then, and they see this graph and I think it's, this is very educational for folks to think about this and to help them understand what's going on with them. So, definitions of moral injury are here on this slide, perpetrating, failing to prevent, bearing witness to or learning about acts that transgress deeply held moral beliefs and expectations, a betrayal of what's right by someone who holds legitimate authority in a high stake situation, a deep sense of transgression including feelings of shame, grief, meaninglessness and remorse when having violating core moral beliefs. So again, you can see how this relates to combat Veterans, to non-combat Veterans, to civilians, to front-line folks, healthcare workers. Moral injury is not post-traumatic stress disorder. Persons with PTSD may also suffer from moral injury, but persons with moral injury may not necessarily have all the symptoms of PTSD. So I believe that the presence of moral injury may complicate the recovery of people with PTSD only receiving treatment that is focused on PTSD, and resolving moral injury may also improve PTSD. So for example, if you're feeling really guilty about accidentally hurting somebody, when you're in the military, or killing somebody, that wasn't a combatant, and you're up at night having insomnia about it, that may be something to really work on with the Veteran. Of course there's an overlap between moral injury and the negative cognitions that are a part of the symptoms of post-traumatic stress disorder. And again, I think one of the big

emotions that I see in folks who are suffering with moral injury is anger, and the lack of forgiveness of themselves. And these are questions that we developed a short scale. Dr. Koenig and I work together and we developed a long scale that is valid for being a Veteran to have moral injury, as well as a short scale, and these are the questions that are on the short scale. So again, if you are interested in these scales let me know, I can provide them to you. They are validated scales on moral injury short form, as well as a longer one. One of the things we looked at we collected data on 570 Veterans and active duty military and found that moral injury was related to a suicide risk index, and so I think that's something to think about when we're interviewing folks who are feeling suicidal. Self-condemnation seemed to have the highest subscale that correlated with moral injury. Religiosity did not mediate the relationship between moral injury and suicide risk. We also looked, with the scale that we collected throughout the country and validating the moral injury scale, religiosity and spirituality, um, and in the past it has been shown that religiosity and spirituality was inversely related to post-traumatic stress symptoms, and positively correlated with post-traumatic growth. In our study of 90% of Veterans with PTSD reported moral injury symptoms and we found that religiosity was inversely related to moral injury in Veterans with severe PTSD. We used a measure that was valid for measuring religiosity in patients called a BIAC, developed by Dr. Koenig. So, when we talk to Veterans, you know, or we're providing Veterans centered care, some Veterans might be interested in talking to chaplains, some may not. So it is important to ask Veterans about their spiritual life and what they're interested in. There is a push from VACO from the head chaplain to incorporate chaplains into all areas of mental health care, which I support, because I think some Veterans really resonate with speaking to a chaplain. Um, and, uh, In one recent publication by one of the colleagues that helped with the development of the scale in 2018, he showed that 80% of Veterans were open to spiritually oriented treatment. So, toward that end, I've been working with Dr. Koenig and Dr. Michelle Pearce, who developed a spiritually integrated form of CPT that explicitly draws on a client's spiritual religious resources and addresses spiritual struggles. Because in Dr. Koenig's model for moral injury, one

of the consequences of moral injury can be that people turn away from spirituality, they turn away, they feel betrayed by their higher power. So, if a Veteran is religious and interested in this, we are now doing a research study to provide spiritually integrated CPT, and it's really targeting moral injury to reduce the PTSD symptoms and we have five religion specific appendices. Again, if anybody is interested in this, let me know. We've had very slow progress with our research, in part because of the pandemic, but if people are interested we really want to get this information out to people. Dr. Pearce has published an article about doing spiritually integrated CPT. And then, we've also developed a chaplain intervention that could be provided by the chaplain, and we've trained all our chaplains here at the VA in Los Angeles. um, it's a 12...It's 12 sessions, it's 50-minute individual one-on-one pastoral care sessions with the Veteran. The intervention is designed to specifically help those who indicate that religion is important in their lives and to be adapted to specific religious beliefs of the Veteran. So we're right now testing this chaplain intervention which is based upon this model of healing, conviction, lament, repentance, confession, forgiveness, reconciliation, atonement, recovery and resilience and anger is an optional part of these 12 sessions that we're testing with chaplains here in Los Angeles. Again, if you are interested in any of my materials, and what we're doing, we want to get it out to you, I know it's not proven yet to work, but if you are interested in learning about this I really want to share this material. We're looking at ten moral injury dimensions – guilt, shame, betrayal, moral concerns, loss of trust, loss of meaning, self-condemnation, difficulty forgiving, religious struggles and loss of religious faith. We've had two Veterans in the chaplain intervention and, again, they came in with very high levels of moral injury. You had to have scores over 250 – and, on the long moral injury scale, which is 45 items, and then our chaplain collected the PCL-5 and the moral injury, these were self-rated forms at every session, and so the blue line shows a decrease in PTSD symptoms with the chaplains working primarily on moral injury. So, as I said, even though PTSD and moral injury are different, I think if you help the moral injury, you can help the PTSD symptoms as we see in this first Veteran who received 12-weeks of chaplain intervention in our

study. And then this is the data from the second Veteran as well. Again, we're seeing the decrease in the PCL-5, the PTSD symptoms, and the score on the moral injury scale is going below the threshold for serious pathology and moral injury. So, um one thing that I think about is that we're all spiritual beings and that we're all struggling with relationships. So, when somebody comes in my office, they're struggling with either a relationship in their past or their present. There's a very famous psychiatrist who used to work at our VA, Dr. Glazier postulated, we're all struggling with relationships. Is it a relationship with ourselves, is it a relationship with others? Is it a relationship with our God or higher power? How do these relationship problems affect our soul, our mind, our will, our emotions? So, um, this is kind of a scale that I really would like to validate. It's looking at these people's relationships on a scale of 1 to 10, how they feel about others, themselves or higher power. If somebody walks in my office, and I only have a one half hour to meet with them, I know that if they have no friends, they hate themselves, they have no sense that there's something bigger than them in their world. That's a person that I'm worried about. And so that would be a person at like the 1, 1, 1 on this scale. Even our work with the Veterans, with the spiritually integrated treatment, we talk a lot about forgiveness and the story of the prodigal son is used in letting people know that they are um they are forgiven and that they are always loved. And I think that, one of, an article that I read, I'm sorry, a book that I read that was really powerful to me was "Tattoos on the Heart" by Father Boyle, who started a Home Boys Industry, where he would take convicted felons and give them jobs, which I thought was amazing because nobody else would give them jobs. And so imagine if we all treated each other with compassion, mercy, forgiveness, grace and unending love, that the prodigal father had for him. I think that's really the key to helping our Veterans and ourselves. So, we've been doing some research with, doing focus groups, with people in the faith based leaders in the community to find out how they are handling Veterans who are struggling in their churches and synagogues, and we got a lot of good information from them on how to help them with connecting Veteran faith, and mental health care at the VA, and we've developed resources for these faith communities that

have been approved by our public relations people here to give to our faith based leaders in the community. We're hoping to continue the dialogue with leaders in the community because they see a lot of struggles in mental heath and we want them to also be aware that there are ways that they can help people with PTSD and moral injury with spiritually integrated interventions. So, in summary, I believe that mental health care and suicide prevention should be recovery-oriented, and include a holistic, bio-psycho-social-spiritual approach. Moral injury should be recognized, as it may explain why Veterans with post-traumatic stress disorder do not fully recover with currently available treatments for PTSD, and Veterans may prefer, and actually benefit from treatments utilizing spiritually integrated approaches. Spiritually integrated interventions for moral injury and PTSD provide VA mental health providers opportunities to collaborate with chaplains and faith-based communities to optimize care of Veterans. I believe a holistic bio-psycho-social-spiritual recovery model must also be applied to ourselves, to optimize our well-being, to support our resilience and prevent burnout. We must all engage in therapeutic lifestyle changes, and support one another on our own recovery journey. And thank you so much for listening today, and I just want to remind folks about the Veteran crisis line and I want to thank all the folks in my lab who have helped me with putting together this work and all our collaborators, research collaborators and I just want to put out a special thanks to the PRRC staff that I worked with over the years. Um, and if you have any questions, feel free to, um, E-mail me – I'd be really happy to send you materials or answer any questions if we can't get to them right now during the question and answer period. Thank you.

Ralf Schneider: Hey, this is Ralf, some questions are coming in, the first one, well, it was a little bit further back, was from Elizabeth Wiley. She asked, "Would the spiritually integrated CPT be provided by someone at the site by VVC – how does that work?"

Dr. Donna Ames: Right now, um, because of the COVID situation, research was on hold for a while, so we got IRB permission and now we can provide it by VVC. So, it's a research project that we're doing, and we're randomizing people to either get this spiritually integrated CPT provided

by um, psychologists trained in CPT, or they will get a chaplain intervention, pastoral counseling as I explained, or they're going to get the treatment, the regular treatment CPT.

Ralf Schneider: Great. Dr. Ames, we had a lot of folks who are interested in your, in the moral injury scales, and we've gotten down their E-mails, so we'll make sure to get those to you at the end. So we have more time for questions from folks. You can put them in the Chat box.

Dr. Donna Ames: I just want to say I didn't spend a lot of time talking about exercise and diet in this talk, but we have a whole curriculum called the Lifestyle Balance Program that we developed through the VA merit review. It is really all about helping our Veterans eat healthy, and I think it's so important, especially now that we provide nutritional counseling to our Veterans because what you eat can really affect your mental and emotional health. It effects your gut micro biome, so I'm always recommending the Mediterranean diet to my Veterans, I also think that supplements can be really helpful for my Veterans. I've noticed that most of my Veterans are vitamin D3 deficient, so I order labs to check on vitamin deficiencies, and I've been supplementing my Veterans with vitamin D3, which can help with emotions – can help actually with the immune system. And there's been some discussion that vitamin D3 deficiency, um, may be related to more of a risk for COVID. So, if you think your Veterans are not doing well nutritionally, make sure that they're getting looked at for that, because we're also seeing in a recent article that Veterans with schizophrenia are more prone to getting COVID. So, if there's obesity, if there's inflammation, we know that that's a problem with COVID. So, I've been giving my Veterans vitamin D3, I give my Veterans Omega 3 supplements for their brain health. So again, I didn't talk a lot about that today, but if you want more information on nutrition or, there's, you know, I definitely think that when you look at your Veterans, ask them if they want help with that, because what you eat affects your mood, it effects everything. It affects your well-being, and even your immune system.

Ralf Schneider: Great. Are there anymore questions? Oh yes, we have a long question that just came up that Ryan Parker sent. Uh, I wonder if that's a comment. He says, "Dr. Ames, in using the MISS-M-SF have you experimented with having the Veterans fill out this scale, as if they were prior to service, and then their actual post-service, but pre-intervention state." He's asking because with Vietnam Veterans in particular, there seems to be both loss of faith and finding of faith in a narratively progressing sense that isn't necessarily the case for post-911 Veterans, wondering how you navigate those sorts of dynamics?

Dr. Donna Ames: Yeah, I think it's really interesting because, um, depending on the generation, and how they were raised, um, how,

what constitutes a moral injury for, you know for maybe a person who has never been exposed to any kinds of religious training. So yeah, that's a very interesting question. And I think one of my colleagues, William Nash, the way I understand his conceptualization of moral injury is that when a person has a moral injury, it changes who they think they are. So, they no longer feel like they were that pre-Vietnam person. A lot of times when we talk to Veterans, they feel like they're no longer that same person, right? That their character has been changed by whatever, morally injurious event that they had. Certainly with military sexual trauma, a person feels like, "I'm never gonna be whole. I'm I'm broken. You know, I'm a different person since this horrible thing happened to me." And that's where recovery comes in, and that's where I think, like the acceptance commitment therapy is so powerful, and people are testing acceptance commitment therapy for moral injury to, you know, help people realize how beautiful and how precious they are despite the things that happened to them, and despite the things they did in their life that they really are strong and resilient. So, building on their strength and helping them with their self-concept. But yeah I think that is a real, can be a real consequence of moral injury, is having a different sense of who you are altogether, like you're no longer that innocent 18-year-old who went over there, now you are something else, and so yeah.

Ralf Schneider: Great. Thank you. We have a couple people uh, that had a few more comments for you. Chad Wolks added, “I’m interested in helping if the SI CPT can be extended toward other VA’s for this initial research.” And he can certainly contact you uh, if he wants to learn more about that. We have Venice Anderson who said, who wanted a copy of the Lifestyle Changes Program, and asked, “What disciplines might be able to deliver that Lifestyle Changes Program? Is it limited to certain clinicians?”

Dr. Donna Ames: That’s a good, very good question. Um, when I had my funding I had two dietitians deliver the program because it involved nutritional counseling and special expertise in that area. So, I think, from my experience , working in the mental health clinic, I think the nursing staff would like ideal. Um, and they’re very enthused and interested in helping Veterans with this. There’s certainly, it could be done in an interdisciplinary fashion. So in other words, if you have a PRRC where you have a nurse, or a mental health clinic where you have a nurse, or an inpatient unit, maybe the nurses could do the exercise and nutrition portion, maybe a social worker could work on the sections that relate to socialization, and you know, recreation activities, maybe even have an occupational therapist who could help with those sorts of things. But yeah, it could be done flexibly with multidisciplinary staff or if you have a staff who is really gung-ho, and really helping and train them up with the therapeutic lifestyle changes to work on. It’s really great to change the conversation with Veterans about what, rather we’re not talking about taking a pill here – we’re talking about making choices that are really positive for you. So let’s talk about the food you're eating. Let’s talk about the exercise you’re doing. Research shows that exercise is as powerful as antidepressants for depression, so why aren’t you exercising? Let’s get going. Sometimes, some of my very amotivated, depressed folks I will put in a consult to physical medicine and have a physical therapist start working with them.

Ralf Schneider: Thank you. So, um, we have Mary [inaudible52:37] who said she is very interested in integrating more spirituality into her therapy work. “I sometimes worry about spirituality not being within my scope as a psychologist. How do I approach this?” And I’m sure that sort of question might apply to other professions too – Dr. Ames.

Dr. Donna Ames: Yeah, I think that’s a really good question. I think it would be something to go over with one’s supervisor. Michelle Pearce has published a spiritually integrated CBT book, and they’re done at least eighteen articles on integrating spirituality into CBT – she and Dr. Koenig. So I think you would have to talk to your supervisor, you would have to perhaps confer with chaplains, and provide sort an interdisciplinary approach to integrating this. And I think I think it would be reasonable to give, you know, informed consent to your Veteran and I think when we talk with Veterans, you know, I think it’s very important when we do an assessment to understand where they are spiritually and who they want the help from. So, um, they may be very interested in talking about their spiritual struggles with a psychologist, or they may prefer to talk to a chaplain. So, good question, and I think that as we see the CBT that's spiritually integrated has been validated, has been published, and now we’re in the process of developing the CPT that is spiritually integrated. So I would imagine the future, if this proves to work, could be added to the armamentarium.

Ralf Schneider: Yes. We just have a little bit more time left for questions, we’ve got about 5 minutes. William Butler asks, “How can this holistic model get patients and providers to reduce medications?”

Dr. Donna Ames: Yeah, that’s a really great question. Um, so often I’ll see Veterans, I have a very busy outpatient mental health clinic with I think about 600 patients, and sometimes I see patients who have been treated for many, many years, and so we talk about unraveling some of the psychopharmacology that has occurred, and trying to integrate these TLC’s into their lives, and some of them are very relieved. They’ll be like, “Why didn’t I meet you ten years ago before I put on all this weight on this medication or had this extrapyramidal side effects?” So, what I talk

about with the Veterans at my very first meeting, is we're going to work on a holistic approach, and that might involve lowering the doses of medications or trying to reduce polypharmacy, and they're very open to it, especially the people who have been in the system a long time. Many of the younger Veterans who come in – I see people from 18 to their 90's. So people, the younger folks are like, "I don't really want to try medications at this point, but I am really interested in this holistic approach", and I can get them interested in vitamins, nutritional supplements. We know that with PTSD, that medications for PTSD are not the number one go-to treatment, that therapy is the go-to treatment, but some of our Veterans really suffer from insomnia, stress, and so when we start looking at the holistic approach, um, I will work up a lot of my Veterans for medical causes of their insomnia, and low and behold, many Veterans with post-traumatic stress disorder have something called sleep apnea ,and so you can make a Veteran's life so much better by getting them evaluated for sleep apnea or if they're really nervous they could have a thyroid condition or a B12 deficiency or, as I said, the vitamin D deficiency. So, I use magnesium a lot as a supplement for my Veterans with post-traumatic stress to help with calming them. Um, and again, a lot of Veterans are interested in this holistic approach and in minimizing medications. I'm finding that many of my older Veterans want to get off and on fewer medicines, and it's very important because many of these medicines taken together can cause cardiac issues, especially in our older Veterans, QT prolongation, which is a serious side effect when we combine too many medications.

Ralf Schneider: Thank you so much Dr. Ames, and we are about out of time. But before we sign off…

[End Recording]