Culturally Responsive PTSD Care 101: The Role of Case Formulation

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VHA Central Office
Office of Mental Health and Suicide Prevention (11MHSP)
October 21, 2020
Learning Objectives

• Define culturally responsive PTSD services
• Explain why mental health providers should be providing culturally responsive PTSD services
• List integral components of a culturally responsive case formulation
Agenda

• Discuss why culturally responsive PTSD care is important
• Discuss terminology
• Summarize models of culturally responsive case formulation
• Provide resources
Thank you!

Providing mental health services to Veterans with PTSD requires skills, compassion and dedication and self-sacrifice.
Poll Question #1

How often do you provide PTSD treatment to culturally diverse Veterans?

I regularly provide PTSD treatment to culturally diverse Veterans

I periodically provide PTSD treatment to culturally diverse Veterans

I rarely provide PTSD treatment to culturally diverse Veterans
Poll Question #2

True or False:

PTSD looks the same in all Veterans, regardless of the Veteran’s race, ethnicity, employment history, gender, sexual orientation, age, religion, socioeconomic status, etc.
Poll Question #3

True or False:

You need to be an expert in cultural diversity to be a culturally responsive clinician
Any competent mental health provider has the ability to provide culturally responsive care.
Why is Culturally Responsive PTSD Care Important?

Because every Veteran is different!
Racial/Ethnic Minority Veterans are about 22% of total Veteran population

Minority Veterans by Race and Hispanic Origin
(in percent)

- AIAN: 0.6%
- Asian: 1.6%
- Black: 11.2%
- Hispanic: 6.6%
- Two or more races: 1.4%
- Some other races: 0.1%

*2014 American Community Survey (ACS) Public Use Microdata Sample (PUMS)
Racial/Ethnic Minority Veterans are Younger

Among young Veterans

Only 7.3% of White Veterans are between 17 to 34 years old; but this figure increases dramatically for all minority groups, with some nearing 20%.

Youngest Veterans: 17 to 34 Years Old (in percent)

- White: 7.3%
- Black: 10.7%
- Asian: 10.9%
- AIAN: 15.9%
- Some other race: 14.2%
- Two or more races: 18.2%
- Hispanic: 18.9%

*2014 American Community Survey (ACS) Public Use Microdata Sample (PUMS)
Women are about 8% of Veteran population

Women and minorities in the military: tomorrow’s Veterans

- In September 2014 there were about 201,359 women on active duty, about 16% of the active force

Source: https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp

- In FY 2013, 39% of non-prior service active component enlisted female accessions were minorities and 17% were Hispanic

Source: https://www.cna.org/pop-rep/2013/appendixb/b_03.html

There was no statistical difference in percent of race between Asian female Veterans and Two or more races female Veterans as well as AIAN female Veterans and Some other race female Veterans.
## Who are we treating in VA?

### Number of Minority Veterans Enrolled in VA Health Care, by VA Health Care Usage: 2005-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Uses VAHC</th>
<th>Enrolled Does not use VAHC</th>
<th>Not Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>871,918</td>
<td>519,836</td>
<td>2,949,130</td>
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<tr>
<td>2006</td>
<td>899,354</td>
<td>550,592</td>
<td>2,906,517</td>
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<td>2007</td>
<td>927,622</td>
<td>575,141</td>
<td>2,850,427</td>
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<td>2008</td>
<td>960,374</td>
<td>594,033</td>
<td>2,803,381</td>
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<td>2009</td>
<td>1,010,043</td>
<td>617,464</td>
<td>2,736,610</td>
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<tr>
<td>2010</td>
<td>1,069,498</td>
<td>640,195</td>
<td>2,662,665</td>
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<tr>
<td>2011</td>
<td>1,117,587</td>
<td>665,589</td>
<td>2,592,889</td>
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<td>2012</td>
<td>1,162,240</td>
<td>691,005</td>
<td>2,516,297</td>
</tr>
<tr>
<td>2013</td>
<td>1,210,094</td>
<td>712,355</td>
<td>2,440,529</td>
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<tr>
<td>2014</td>
<td>1,261,559</td>
<td>729,377</td>
<td>2,371,571</td>
</tr>
</tbody>
</table>

**Source:** U.S. Veterans Eligibility Trends and Statistics, 2014
Prepared by the National Center for Veterans Analysis and Statistics
VHA Utilization Varies by Race/Ethnicity

Service-connected Disabled Veterans Receiving Compensation and VA Health Care use by Race/Ethnicity: FY 2017
(in percent)

Average VHA Utilization rate = 69.6%

Disabled, but did not use health care
- White: 32.4%
- Black or African-American: 22.6%
- Asian: 37.5%
- American Indian/Alaskan-Native: 29.1%
- Native Hawaiian/Pacific Islander: 33.5%
- Hispanic: 28.5%
- Other: 31.5%

Disabled & used health care
- White: 67.6%
- Black or African-American: 77.4%
- Asian: 62.5%
- American Indian/Alaskan-Native: 70.9%
- Native Hawaiian/Pacific Islander: 66.5%
- Hispanic: 71.5%
- Other: 68.5%

Source: U.S. Veterans Eligibility Trends and Statistics, 2017
Prepared by the National Center for Veterans Analysis and Statistics
Growth in Women Veterans Using VA is >5x The Growth Rate of the Women Veteran Population

- Number of female Veteran users increased by 51.8% since 2008 while the total number of female Veterans increased by only 9.8%.
- Number of female Veterans grew at an average annual rate of 1.0% between FY 2008 and 2017, while the number who used VA benefits has grown at an average rate of 4.8%.
- The utilization rate of VA benefits among female Veterans increased from 36.3% in 2008 to 50.3% in 2017.
- Female Veterans made up 9.6% of all users in 2017, up from 7.0% in 2008.

Source: U.S. Veterans Eligibility Trends and Statistics, 2017
Prepared by the National Center for Veterans Analysis and Statistics
Racial and Ethnic Issues in VHA Mental Health/PTSD Treatment

A few examples:

• Black Veterans less likely to receive service connection for PTSD even after controlling for PTSD sx severity and level of functional impairment—Rosen, et al., 2013

• African American Veterans suggested providers focus initial MH visits on getting to know client, including goals and preferences, connect as “humans,” be mindful of behaviors, thoughts and emotions—Eliacin, et al., 2016

• Black Veterans were less likely than White Veterans to be diagnosed with PTSD in VA Compensation and Pension exams—Marx, et a., 2017

• African American Veterans observe lack of racial diversity in VHA settings and perceive providers fear Black patients, and fear being judged negatively based on stereotypes—Eliacin, et al., 2020
Current Status of PTSD Treatment and Racial/Ethnic Minorities (McClendon, Dean & Galovski, 2020)

**PTSD Treatment Engagement**
- PTSD tx engagement among PoC is mixed, some suggestion that Black/Af Am are less likely to initiate
- PTSD tx retention also mixed for B/Af Am, but Latinx less likely to complete tx
- Difference in type of study—record review v. RCT

**PTSD Symptom Reduction**
- Research is limited
- Lack of evidence for differences

**Culturally Adapted PTSD Treatment**
- May improve acceptability and retention in tx

**More research is needed!**
Why should we provide culturally responsive PTSD care?

VHA I CARE values

- **Integrity**: Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage.

- **Commitment**: Work diligently to serve Veterans and other beneficiaries. Be driven by an earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities.

- **Advocacy**: Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interests of Veterans and other beneficiaries.

- **Respect**: Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it.

- **Excellence**: Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them.
SAMHSA (2014): Trauma Informed Approach

- **4 Rs**
  - Realize
  - Recognize
  - Respond
  - Resist re-traumatization

- **Six key principles of a trauma-informed approach:**
  - Safety
  - Trustworthiness and transparency
  - Peer support
  - Collaboration and mutuality
  - Empowerment, voice, and choice
  - Cultural, historical, and gender issues
Some Terminology
Equality vs. Equity

In the picture, 'Equality' represents the concept where everyone starts from the same point and is given the same opportunities. 'Equity' represents the idea of providing the right resources and support to meet individual needs, ensuring everyone has the chance to succeed.
Cultural Competence
(The Joint Commission, 2010)

“The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter.”

Cultural competence requires organizations and their personnel to do the following:

(1) **value diversity**;
(2) **assess themselves**;
(3) **manage the dynamics** of difference;
(4) acquire and **institutionalize cultural knowledge**;
and
(5) **adapt** to diversity and the cultural contexts of individuals and communities served.
Cultural Responsiveness (HHS.gov Think Cultural Health)

• Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
  • Principle Standard of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (2013), US Department of Health and Human Services
Cultural Humility  (Hook, Davis, Owen, Worthington & Utsey, 2013)

• “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]” (p. 2).
  • lifelong commitment to self-evaluation and self-critique
  • desire to fix power imbalances where none ought to exist
  • aspiring to develop partnerships with people and groups who advocate for others
Important Sidebar About Context: The Current Climate
Poll Question #4:

How much has the COVID-19 pandemic affected your WORK life?

Significantly
Moderately
A little
Not at all
Poll Question #5

How has the COVID pandemic affected your PERSONAL Life?

Significantly
Moderately
A little
Not at all
The COVID-19 pandemic

- Disrupted all sectors of the US and the world
  - Acute and ongoing effects
- Brought to light disparities in healthcare, especially for Black/African Americans and Native Americans
- Brought to light problems with how race/ethnicity data is captured by our healthcare system
- For mental health providers--major pivot to providing virtual care: Complications
  - Technology
  - HIPPA
  - Group care
Use your personal experience to tap into EMPATHY for the Veterans you serve

• How has the COVID Pandemic affected their work lives?
  • Laid off/fired from job
  • Unable to find employment

• How has COVID Pandemic affected their personal lives?
  • How does this affect their finances and everything financially related?
    • Housing, food, clothing
    • Physical distancing
    • Isolated/too much contact with family/friends
    • Access to healthcare?

These experiences should be integrated into your case formulation
“Please I can’t breathe. My stomach hurts. My neck hurts. Everything hurts. They’re going to kill me.”

GEORGE FLOYD
Poll Question #6

How has Racial injustice affected your WORK Life?

Significantly
Moderately
A little
Not at all
Poll Question #7

How has Racial injustice affected your PERSONAL Life?

Significantly
Moderately
A little
Not at all
Each would be difficult enough separately, but combined, COVID and racial injustice have even greater negative effects

- How has racial injustice affected your Veteran clients’ work lives?
  - Racism at work
    - Supervisor/boss and coworker interactions
    - Customers
  - Lack of psychological safety
  - Physical safety issues
- How has racial injustice affected your Veteran clients’ personal lives?
  - Past racism causing re-experiencing of trauma?
    - Self, family, friends
  - Influence of racial/ethnic identity
  - Connection to law enforcement
  - Experiencing microaggressions

These experiences should be integrated into your case formulation
Models of Culturally Responsive Case Formulation
Case Formulation/Conceptualization

• Understanding of the client’s clinical presentation in context
• Necessary for the customization of treatment
• Initially developed during the initial assessment/intake phase of treatment
  • Update as needed throughout treatment
• Key content areas provide information on
  • Etiology of presenting problem
  • Precipitating factors
  • Risk factors that maintain and exacerbate the problem
  • Strengths and supports
• Road map for therapy: Identifies areas in therapy where therapeutic interventions can be implemented:
  • Cognitions
  • Behaviors
  • Emotions
• Ongoing collaborative review and update with client during treatment
• Presupposes the development of basic interviewing and therapeutic skills
ADDRESSING Framework (Hays, 2012, 2016)

Age/generation, Developmental and other Disabilities, Religious and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender
Culturally Informed Functional Assessment (CIFA) Interview
(Tanaka-Matsumi, Seiden & Lam, 1996)

• Goals
  • Increase **accuracy** of case formulation and diagnosis
  • Enhance development of therapeutic **rapport**
  • Enhance **client’s expectations** for positive change
  • Increase **client participation** and involvement in treatment

• Similar to functional analysis: identification of **causal functional relationships** that can be applied to target behaviors

• Purpose is to **generate hypotheses** about antecedents and consequences in context
### Culturally Informed Functional Assessment (CIFA) Interview

<table>
<thead>
<tr>
<th>Areas to Assess</th>
<th>Client</th>
<th>Family</th>
<th>Group</th>
<th>Clinical Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1. Cultural identity and acculturation</strong></td>
<td>Language; culture of social support group; acculturative mode; acceptance v. rejection v. marginalization v. integration; monocultural versus bilingual</td>
<td>Discrepancies between the client’s acculturation and the acculturation of family members</td>
<td>Behavior of the client’s cultural reference group and the host culture toward a person with the client’s cultural identity and acculturation status</td>
<td>Decide whether to continue the assessment alone, to use a translator or cultural consultant, to read relevant literature or to refer the client to a different clinician</td>
</tr>
<tr>
<td><strong>Step 2. Presenting problems:</strong></td>
<td>Cognition, affect, behavior, somatic complaints; problem frequency, duration, perversiveness, magnitude; client’s behavior in the interview</td>
<td>Family’s conceptualization of the client’s problem</td>
<td>Comparison of the client’s problems and idioms of distress with the norms of the client’s cultural reference group and with symptoms of culture-bound syndromes</td>
<td>Distinguish maladaptive behavior and thought disorder from culturally normative behavior and idioms of distress; distinguish what may appear to be adaptive behavior from that which deviates from the client’s cultural norms</td>
</tr>
<tr>
<td>Excesses, deficits, labels</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Step 3. Elicitation of causal explanatory model (EM)</strong></td>
<td>Client’s causal EM of the problem</td>
<td>Family’s causal EM of the problem</td>
<td>Comparison of the client’s EM with culturally normative folk, religious and community beliefs</td>
<td>Distinguish what may appear to be thought disorder from culturally normative EMs</td>
</tr>
<tr>
<td><strong>Step 4. Functional assessment:</strong></td>
<td>Historical and current determinants of responses; Environmental and organic antecedents and consequences; motivation to change; natural reinforcers</td>
<td>Consequences of the problem for the family; new problems possibly created by “successful” treatment</td>
<td>Comparison of the client’s reactions to stimuli with typical reactions of the client’s cultural reference group to similar stimuli</td>
<td>Formulate a tentative clinical EM of the development and maintenance of the client’s problem based upon the functional assessment, subject to ongoing evaluation and revision</td>
</tr>
<tr>
<td>1. Important, causal and modifiable variables</td>
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<tr>
<td>2. Motivation to change</td>
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<tr>
<td>3. Natural reinforcers</td>
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### Culturally Informed Functional Assessment (CIFA) Interview

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<th>Group</th>
<th>Clinical Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 5. Comparison and negotiation of causal explanatory models</td>
<td>Client's opinion of clinician's EM</td>
<td>Family's opinion of clinician's EM</td>
<td>Opinions of other cultural informants as to clinician’s EM</td>
<td>Negotiate an EM consistent with effective and feasible treatment</td>
</tr>
<tr>
<td>Step 6. Generation, comparison and negotiation of treatment variables</td>
<td>Client's help-seeking behavior and past experience with lay and professional helpers; client's own proposals for treatment variables; acceptability and perceived consequences of clinician's proposals</td>
<td>Family's help-seeking behavior and past experience with lay and professional helpers; family's proposals for treatment variables; acceptability and perceived consequences of clinician's proposals</td>
<td>Existence of indigenous techniques or healers for the problem; acceptability of specific lay and professional help-givers and techniques</td>
<td>If standard behavioral treatment variables are not accepted by the client or family, generate and negotiate alternatives</td>
</tr>
<tr>
<td>1. Treatment goals</td>
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<tr>
<td>2. Target behaviors</td>
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<tr>
<td>3. Change agents</td>
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<tr>
<td>4. Techniques</td>
<td></td>
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<tr>
<td>Step 7. Generation, comparison and negotiation of data collection procedures</td>
<td>Acceptability and perceived consequences of data collection</td>
<td>Acceptability and perceived consequences of data collection</td>
<td>Opinions of other cultural informants as to acceptability and perceived consequences of data collection</td>
<td>If standard data collection is not accepted, generate and negotiate alternatives</td>
</tr>
<tr>
<td>Step 8. Discussion of treatment duration, course and expected outcome</td>
<td>Client's concerns about treatment</td>
<td>Family's concerns about treatment</td>
<td>Other cultural informants' concerns about treatment</td>
<td>Decide whether to treat the client or to suggest alternatives</td>
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Cognitive Behavioral Case Conceptionalization
(Wenzel, Dobson & Hays, 2016)

• Cognitive Behavioral Therapy (CBT) starts with **assessment**
  • Assessment may start prior to treatment
    • Intake paperwork
    • Development of treatment engagement, establishing rapport
  • Assessment types: Clinical interview, self-report data, self-monitoring, behavioral observation, collateral information

• Case conceptualization is the process where the CB therapist uses the data from the assessment to **understand the client’s presentation** within a cognitive behavioral model
• **Vulnerability Factors**
  - Cultural
  - Environmental
  - Biological
  - Psychological

• **Beliefs**
  - Helpful
  - Unhelpful Core Beliefs
  - Unhelpful Rules and Assumptions
  - Unhelpful Compensatory Strategies

• **Stressors**
  - Chronic
  - Acute

• **Situational Manifestations**
  - Situation
  - Automatic Thoughts
  - Emotional Reaction
  - Physiological Reaction
  - Behavioral Reaction
DSM-5 Cultural Formulation (American Psychiatric Association, 2013)

• Efforts to emphasize cultural factors in DSM-5
  • Cultural influences are dynamic
  • Identity varies widely

• Cultural variations in diagnoses discussed: Examples
  • Schizophrenia
  • Panic Disorder
  • V Codes: Religious/spiritual problem, Acculturation difficulty

• Cultural syndromes, idioms of distress, explanatory models
  • Glossary of cultural concepts
DSM-5 Outline for Cultural Formulation

• Cultural identity
• Cultural conceptualization of distress
• Psychosocial stressors and cultural features of vulnerability and resilience
• Cultural aspects of provider-patient relationship
• Overall cultural assessment

• Cultural Formulation Interview
  • 16 item Patient version
  • Informant version
  • 12 supplemental modules
Cultural Formulation Interview

- **Cultural definition** of the problem
- **Cause** of the problem
- **Stressors** and supports
- **Role of cultural identity**—do not assume!
- **Coping**, past treatments
- **Barriers**
- **Preference** for type of help
- **Provider-patient relationship**
  - Provider’s self-awareness as a cultural being

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**GUIDE TO INTERVIEWER**

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual’s social network (i.e., family, friends, or others involved in current problem). This includes the problem’s meaning, potential sources of help, and expectations for services.

**INTRODUCTION FOR THE INDIVIDUAL:**

I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

**CULTURAL DEFINITION OF THE PROBLEM**

(Explanatory Model, Level of Functioning)

1. What brings you here today?
   - \*If individual gives few details or only mentions symptoms or a medical diagnosis, probe for people's understanding of their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?\*

2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you...
Using the Case Formulation: Treatment Planning

- **Identify** the problem(s)
- **Determine** objective ways to measure progress
- **Identify** customized strategies and interventions client will use
- **Collaboratively** discuss formulation and treatment plan with client
- **Ongoing** check-ins regarding formulation and treatment plan
  - Regularly timed
  - Stuck points

### Problem Formulation

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Manifestations of Problem Area</th>
<th>Indicators of Progress</th>
<th>Therapeutic Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Area #1 Problems in romantic relationships</td>
<td>1. Limited social skills</td>
<td>1. Remain in conversation until it naturally comes to a close.</td>
<td>1. Social skills training</td>
</tr>
<tr>
<td></td>
<td>2. Difficulty accurately inferring social cues</td>
<td>2. Verify interpersonal assumptions before acting on them.</td>
<td>2. Social problem solving</td>
</tr>
<tr>
<td></td>
<td>3. Inaccurate expectations for relationships</td>
<td>3. Initiate an appropriate number of connections with potential romantic partners.</td>
<td>3. Cognitive restructuring</td>
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<td></td>
<td>4. Tolerate infrequent contact with potential romantic partners at the beginning of a relationship.</td>
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Selected Resources

External Resources
- VHA Office of Health Equity For Healthcare Professionals (public site)
- AVAPL Psychologists of Color and Allies SIG
- CMS Office of Minority Health
- HHS.gov Think Cultural Health
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Internal VHA Resources
- VHA Office of Health Equity (Internal VA site)
- VHA OMHSP Discrimination, Bias and Equity Resources SharePoint
- VHA Center for Minority Veterans
- VA Psychology Training Council Model Curriculum, Didactic & Instructional Materials
Thank you for coming today!
References


Please enter your questions in the Q&A box and be sure to include your email address.

*The lines are muted to avoid background noise.*
Welcome users of VHA TRAIN!

To obtain continuing education credit please return to www.vha.train.org after the lecture.

TRAIN help desk: VHATRAIN@va.gov
PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS
(866) 948-7880 or PTSDconsult@va.gov

CEU Process for users of VHA TRAIN (non-VA)
Registration → Attendance → Evaluation → Certificate

Register in TRAIN.
Listen to the lecture.
Return to TRAIN for evaluation.
Follow the directions to print certificate.

TRAIN help desk: VHATRAIN@va.gov
CEU Process (for VA employees)

1. **Registration**
   - Register in TMS.

2. **Attendance**
   - Join via TMS and listen to the lecture.

3. **Posttest**
   - Posttest is no longer required for this lecture.

4. **Evaluation**
   - Return to TMS and complete evaluation.
   - Search “My Learning” to find it.

5. **Certificate**
   - Print certificate from “My History” section of TMS.

Contact Information:

(866) 948-7880 or PTSDconsult@va.gov
PTSD Consultation Program
We can help

HEALTHCARE PROVIDERS:
- Are you treating Veterans with PTSD? We can help
- Do you have questions about the mental health effects of the COVID-19 pandemic? We can help
- Are you looking for ways to care for yourself and your colleagues? We can help

PTSDconsult@va.gov
866-948-7880
www ptsd va gov/consult
## UPCOMING TOPICS

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 18</td>
<td>PTSD and Suicide Risk</td>
<td>Ryan Holliday, PhD</td>
</tr>
<tr>
<td>December 16</td>
<td>The Nuts &amp; Bolts of Providing PTSD Treatment over a Telehealth Modality: Clinical Considerations</td>
<td>Leslie Morland, PsyD</td>
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<tr>
<td>January 20</td>
<td>[To be determined]</td>
<td></td>
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<tr>
<td>February 17</td>
<td>PTSD and Racial Trauma</td>
<td>Monnica Williams, PhD</td>
</tr>
</tbody>
</table>

**SAVE THE DATE:** Third Wednesday of the Month from 2-3PM (ET)

For more information and to subscribe to announcements and reminders go to [www ptsd va gov consult](http://www.ptsd.va.gov/consult)
PTSD Consultation Program

FOR PROVIDERS WHO TREAT VETERANS

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www ptsd va gov/consult