



## Sleep Disorders: An Overview of Sleep Disorders Common in Military Members

Center for Deployment Psychology  
Uniformed Services University of the Health Sciences

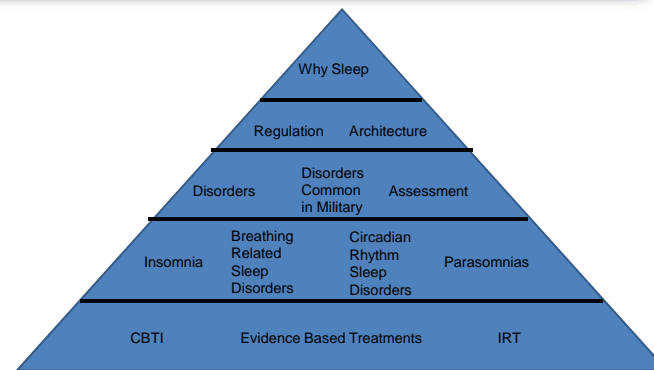


## Disclaimer

The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.



## Understanding Sleep





## Sleep What is it good for?

"I'll sleep when I'm dead"  
-Warren Zevon



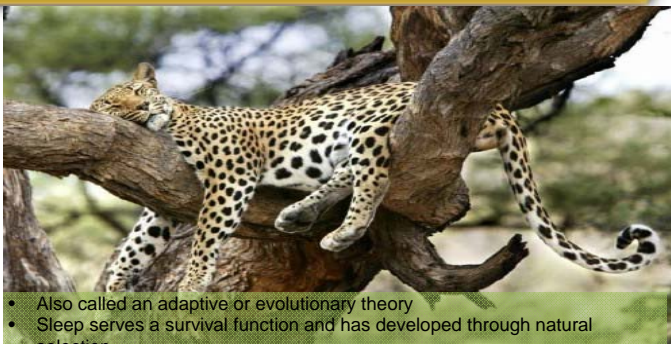
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6



## Inactivity Theory



- Also called an adaptive or evolutionary theory
- Sleep serves a survival function and has developed through natural selection
- Animals that were able to stay out of harm's way by being still and quiet during times of vulnerability, usually at night...survived.



7



## Energy Conservation



- Related to inactivity theory
- Suggests primary function of sleep is to reduce energy demand and expenditure
- Research has shown that energy metabolism is significantly reduced during sleep

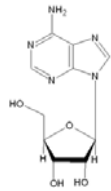


8



## Restorative

- Sleep provides an opportunity for the body to repair and rejuvenate
- Major restorative functions such as muscle growth, tissue repair, protein synthesis and growth hormone release occur mostly or exclusively during sleep



- Adenosine builds up while we are awake (and promotes a drive to sleep) and is cleared from the system while we sleep.



9



## Brain Plasticity

- One of the most recent theories is based on findings that sleep is correlated to changes in the structure and organization of the brain.



- Sleep plays a critical role in brain development with infants and children spending 12-14 hours a day sleep and a link to adult brain plasticity is becoming clear as well



10



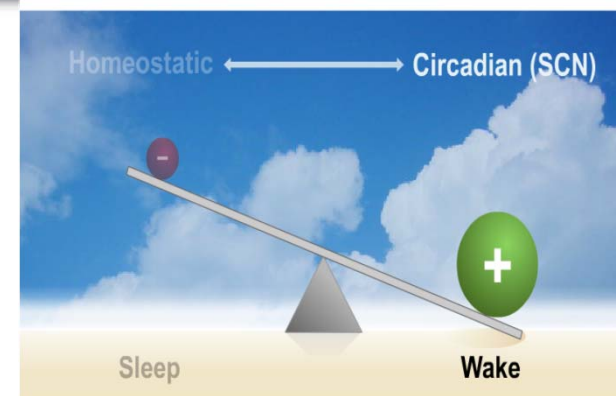
## How is sleep regulated?

- Early scientists believed that gases rising from the stomach during digestion brought on the transition to sleep.

Aristotle (c350 B.C.) "We awaken when the digestive process is complete"



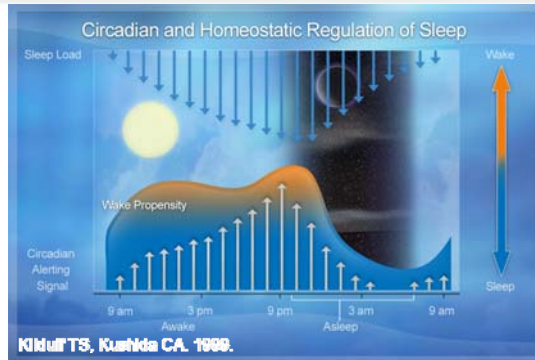
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12



## How is sleep regulated?

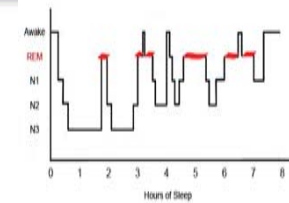


13



## Sleep architecture

- N1 or Stage 1 (5%)
  - 5 mins; transitional phase
  - Low arousal threshold
- N2 or Stage 2 (50-55%)
  - 10-15 mins;
- N3 or Stage 3 & 4 (20%)
  - Lasts 20-40 mins; “delta” “slow-wave sleep”
- REM (20%)
  - Tonic (hypotonic muscles) and Phasic (eye movement) stages



14



## Sleep-Wake Disorders



15



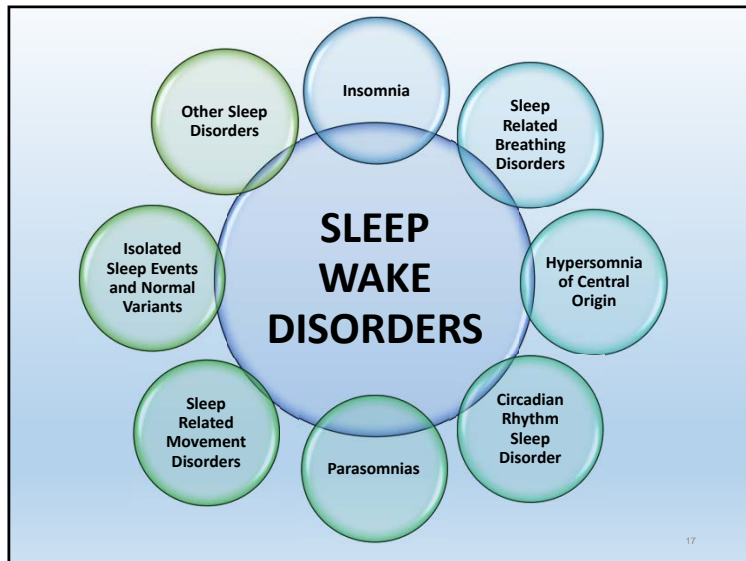
## Disorders

- The International Classification of Sleep Disorders-2 lists more than 80 distinct sleep disorders in 8 categories
- The DSM-5 Classification of Sleep Wake Disorders includes;
  - Insomnia
  - Narcolepsy
  - Breathing Related Sleep Disorders
  - Circadian Rhythm Sleep Disorders
  - Parasomnias

APA, 2013



16



**Disorders Common in the Military**

- The most common complaint of military members returning from deployment is about sleep
- There has been a rise in the number of service members receiving treatment for;
  - Insomnia
  - Obstructive Sleep Apnea
  - Circadian Rhythm Sleep Disorders
    - Delayed Sleep Phase
    - Shift work type
  - Nightmares

hjf 18

**Assessment of Sleep Disturbance**

hjf 19

**Assessment Goals**

- Differential Diagnosis
  - Insomnia vs other sleep disorders
- Is referral to a sleep specialist or primary care provider needed
  - Obstructive Sleep Apnea
  - Restless Leg Syndrome
  - Other medical or psychiatric condition

hjf 20



## Assessment Measures

- Retrospective
  - Clinical Interview
  - Epworth Sleepiness Scale
  - Morning and Eveningness Questionnaire
  - Dysfunctional Beliefs and Attitudes Scale
  - Insomnia Severity Index
  - STOP
  - RLS
- Prospective
  - Sleep Diary



21



## ESS

- How Sleepy in the recent past: Epworth Sleepiness Scale  
0= no chance of dozing 1= slight 2= moderate 3= high

Situation:

- Sitting and reading
- Watching TV
- Sitting, inactive in a public place (e.g. a theater or meeting)
- As a passenger in car for an hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car, while stopped for a few minutes in traffic



22



## MEQ

### MORNINGNESS-EVENINGNESS QUESTIONNAIRE (MEQ)

Instructions:  
 • Please read each question very carefully before answering.  
 • Please answer each question as honestly as possible.  
 • Answer ALL questions.  
 • Each question should be answered independently of others. Do NOT go back and check your answers.

1. What time would you get up if you were entirely free to plan your day?

5:00 - 6:00 AM	1
6:00 - 7:00 AM	2
7:00 - 8:00 AM	3
8:00 - 9:00 AM	4
9:00 - 10:00 AM	5
10:00 AM - 11:00 AM	6
11:00 AM - 12:00 PM	7

2. What time would you go to bed if you were entirely free to plan your evening?

8:00 - 9:00 PM	1
9:00 - 10:00 PM	2
10:00 PM - 11:00 PM	3
11:00 - 12:00 AM	4
12:00 - 1:00 AM	5
1:00 AM - 2:00 AM	6

3. If there is a specific time at which you have to get up in the morning, to what extent do you depend on being woken up by an alarm clock?

Not at all dependent	1
Slightly dependent	2
Fairly dependent	3
Very dependent	4

4. How easy do you find it to get up in the morning (when you are not woken up unexpectedly)?

Not at all easy	1
Slightly easy	2
Fairly easy	3
Very easy	4



23

Horne & Ostberg (1976).



## DBAS

### DBAS-16 Items

#### Dysfunctional Beliefs and Attitudes about Sleep (DBAS)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, circle the number that corresponds to your own personal belief. Please respond to all items even though some may not apply directly to your own situation.

Strongly Disagree 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree

- I need 8 hours of sleep to feel refreshed and function well during the day.  
0 1 2 3 4 5 6 7 8 9 10
- When I don't get proper amount of sleep on a given night, I need to catch up on the next day by sleeping or on the next night by sleeping longer.  
0 1 2 3 4 5 6 7 8 9 10
- I am concerned that chronic insomnia may have serious consequences on my physical health.  
0 1 2 3 4 5 6 7 8 9 10
- I am worried that I may lose control over my abilities to sleep.  
0 1 2 3 4 5 6 7 8 9 10
- After a poor night's sleep, I know that it will interfere with my daily activities on the next day.  
0 1 2 3 4 5 6 7 8 9 10
- In order to be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.  
0 1 2 3 4 5 6 7 8 9 10
- When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.  
0 1 2 3 4 5 6 7 8 9 10



24

Espie, Inglis, Harvey, & Tessler (2000).

**ISI**

**Insomnia Severity Index**

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the Y-axis lines for Scoring/Interpretation below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT or LAST 2 WEEKS SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?  
Very Satisfied    Satisfied    Moderately Satisfied    Dissatisfied    Very Dissatisfied  
0                    1                    2                    3                    4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impacting the quality of your life?  
Not at all    A Little    Somewhat    Much    Very Much Noticeable  
0                    1                    2                    3                    4

6. How WORRIED/EXHASTED are you about your current sleep problem?  
Not at all    A Little    Somewhat    Much    Very Much Worried  
0                    1                    2                    3                    4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/school, concentration, nervousness, etc.)?  
Not at all    A Little    Somewhat    Much    Very Much Interfering  
0                    1                    2                    3                    4

**Guidelines for Scoring/Interpretation:**  
Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = \_\_\_\_\_ your total score

**Total score categories:**  
0-7 = No clinically significant insomnia  
8-14 = Subthreshold insomnia  
15-21 = Clinical insomnia (mild-to-severe)  
22-28 = Clinical insomnia (severe)

Read the names of www.medscape.com with permission from Charles W. Morin, Ph.D., Harvard Medical School

hjf 25

Bastien, Vallières, & Morin, (2001).

**STOP**

- Quick screen for Obstructive Sleep Apnea
  - Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
  - Tired: Do you often feel tired, fatigued, or sleepy during the daytime?
  - Observed
  - Blood Pressure

hjf 26

**RLS**

**Screening Questionnaire:**

**Restless Legs Syndrome**

**(Bedpartner Version)**

Partner's Name: \_\_\_\_\_

Person filling out form: \_\_\_\_\_

1. Does your partner have "leg pains"? (Check One)

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1/month) (1-2/month) (1-2/week to daily)

2. Does your partner complain of uncomfortable or funny feelings (creeping, crawling, tingling in heather legs)? (Check One)

\_\_\_\_\_ never \_\_\_\_\_ occasionally \_\_\_\_\_ sometimes \_\_\_\_\_ frequently  
(less than 1/month) (1-2/month) (1-2/week to daily)

3. Does your partner:

A. Notice burning feelings in heather legs (or do they seem worse) when lying down or sitting? \_\_\_\_\_

B. Have partial relief with movement (tapping feet, toes, or walking)? \_\_\_\_\_

C. Complain that the feelings are worse at night? \_\_\_\_\_

D. Have a lot of fidgeting or wiggling of the feet or toes when sitting or lying down? \_\_\_\_\_

E. Have repeated jerking movements in toes or legs or the whole body while sleeping? \_\_\_\_\_

hjf 27

Hening, Walters, Allen, Montplaisir, Myers, & Ferini-Strambi, (2004).

**Sleep Diary**

**TWO WEEK SLEEP DIARY**

**INSTRUCTIONS:**

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (|) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

**SAMPLE ENTRY BELOW:** On a Monday when I worked, I gaged on my lunch break at 1 PM, had a glass of wine with dinner at 8 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around MIDNIGHT, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, had coffee and medicine at 7:00 in the morning.

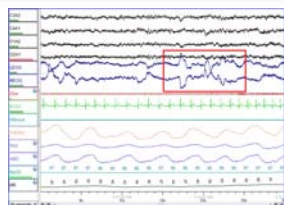
Today's Date	Day of the week	Type of Day (Work, School, Day Off, or Vacation)	Hour	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM	Midnight	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM
sample	Mon.	Work																								

hjf 28





## Objective Measures of Sleep



- Polysomnography – (PSG) overnight sleep study
- Multiple Sleep Latency Test (MSLT) – measure of daytime wakefulness
- Actigraphy – monitors human movement cycles
- There's an app for that



## Sleep Interview

- A complete assessment of sleep disorders will include an interview that includes;
  - Sleep History
  - Functional Analysis (Antecedents, Consequences, etc.)
  - Dietary, Substance use, and Exercise Habits
  - Bedroom environment including Bed partner habits
  - Beliefs and attitudes about sleep
  - Medical History
  - Medication Use
  - Psychological Screening



## Bedroom Environment

- Sleeping with bed partner
- Mattress
- Quiet
- Stereo/radio bedroom
- Desk in bedroom/Computer
- Exercise in bedroom
- TV
- Read
- Snack
- Temperature



## Symptoms of Sleep Problems

- RLS
  - Crawling or aching feeling in legs
  - An inability to keep legs still
- PLMS
  - Leg twitches or jerks during the night
  - Waking up with cramps in legs
  - Bed partner report
  - Find covers all kicked off





## Symptoms of Sleep Problems

- OSA
  - Snoring
  - Pauses in your breathing at night
  - Choking at night
  - Gasping for air during the night
  - Morning headaches, chest pain, or dry mouth
  - Partner report



## Symptoms of Sleep Problems

- Nightmares
- Dream-like images (hallucinations) in am
- Awakening from sleep screaming and confused
- Sleepwalking
- Narcolepsy
  - Sudden “attacks” of sleep during the day
  - Sudden muscular weakness in situations of high stress



## Harvard University Sleep Lab Website

<http://healthysleep.med.harvard.edu/>



[http://healthysleep.med.harvard.edu/interactive/sleep\\_lab](http://healthysleep.med.harvard.edu/interactive/sleep_lab)



## DSM-5 – Insomnia Disorder 780.52

- A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms – difficulty initiating sleep, difficulty maintaining sleep, early morning awakening
- Sleep complaint is accompanied by significant distress or impairment in social, occupational or other important area of functions by presence of at least one of the following
- 3 nights per week
- Present for 3 months
- Occurs despite adequate opportunity for sleep
- Insomnia is not better explained by and does not occur exclusively during the course of another sleep wake disorder
- Not attributable to substances
- Coexisting mental disorders and medical conditions do not adequately explain the insomnia



## DSM-5 Insomnia Disorder

- Episodic – Symptoms last at least 1 month but less than 3 months
- Persistent – Symptoms last 3 months or longer
- Recurrent – Two or more episodes with the space of 1 year

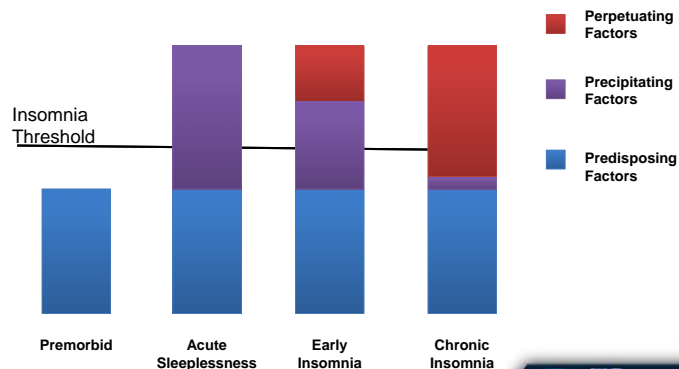


## Factors Involved in Insomnia: Behavioral Model of Insomnia

- Predisposing Factors
  - Arousal level
  - Genetics
  - Worry or rumination tendency
  - Previous Episodes
  - Sleep schedule
- Precipitating Factors
  - Situational Stressors
    - Illness or injury
    - Acute stress reactions
    - Environmental Changes
  - Sustained/Continuous Ops?
- Perpetuating Factors
  - Maladaptive Habits
  - Dysfunctional Cognitions

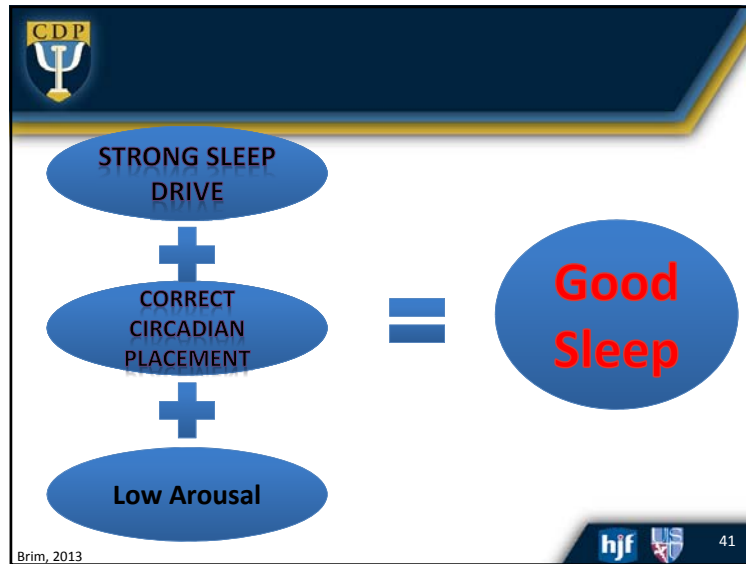


## Evolution from Sleep Disturbance to Insomnia



Chronic insomnia is a major public health problem affecting millions of individuals, along with their families and communities. Evidence supports the efficacy of cognitive-behavioral therapy and benzodiazepine receptor agonists in the treatment of this disorder, at least in the short term. Very little evidence supports the efficacy of other treatments, despite their widespread use.

- 2005 NIH State of the Science Conference on Manifestations and Management of Chronic Insomnia in Adults



- CDP
- ## CBTI Targets
- Behaviors
    - Increase sleep drive
    - Optimize congruency between circadian clock and placement of sleep opportunity (time in bed)
    - Strengthen the signals from the circadian clock
    - Strengthen the bed as cue for sleep (conditional insomnia)
    - Reduce physiological arousal
  - Cognitions
    - Reduce sleep effort
    - Reduce cognitive arousal
    - Address dysfunctional beliefs about sleep
    - Address obstacles in adherence
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- 42

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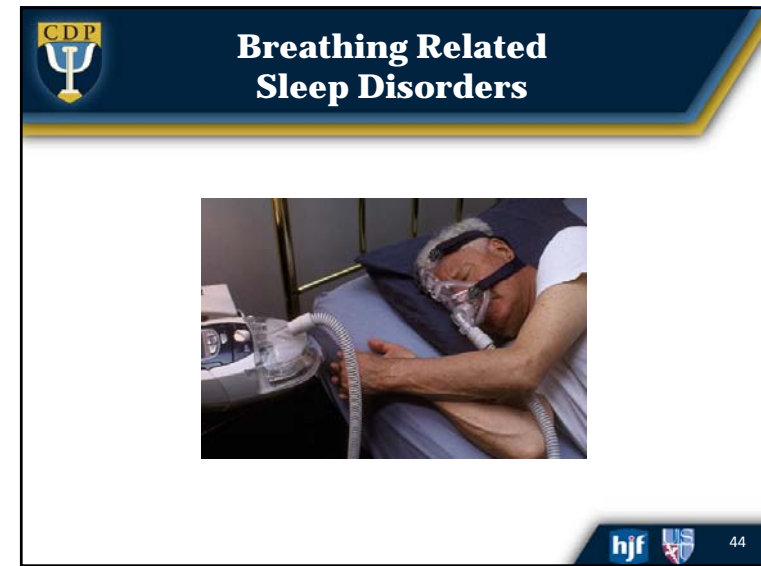
## CBTI Components

Technique	Goal
Stimulus Control	Strengthen bed & bedtime as sleep cues
Sleep Restriction	Restrict time in bed to increase sleep drive and consolidate sleep
Relaxation, buffer, worry time	Arousal reduction
Sleep Hygiene	Address substances, exercise, eating and environment
Cognitive Restructuring	Address thoughts and beliefs that interfere with sleep and adherence
Circadian Rhythm Entrainment	Shift or strengthen the circadian sleep wake rhythm

Brim, 2013

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43





## Breathing Related Sleep Disorders

- Obstructive Sleep Apnea
- Central Sleep Apnea
  - Idiopathic central sleep apnea
  - Cheyne-Stokes breathing
  - Central sleep apnea comorbid with opioid use
- Sleep Related Hypoventilation
  - Idiopathic hypoventilation
  - Congenital central alveolar hypoventilation
  - Comorbid sleep-related hypoventilation



## Treatment

- Constant Positive Airway Pressure (CPAP)
- Bilevel Positive Airway Pressure (BPAP)
- Surgery (uvulopalatopharyngoplasty – UPPP)
- Mouthpiece

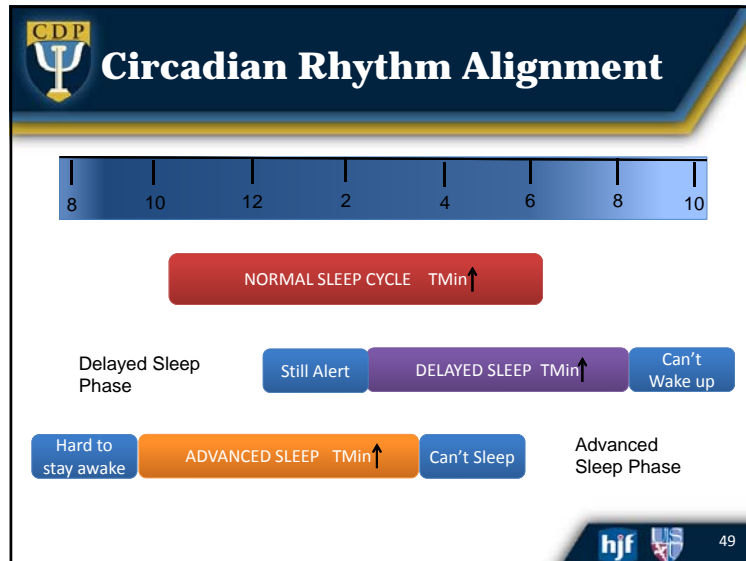


## Circadian Rhythm Sleep Disorders



## Circadian Rhythm Sleep Disorders

- Circadian rhythm sleep disorders
  - Delayed sleep phase type
  - Advanced sleep phase type
  - Irregular sleep-wake type
  - Non-24 hour sleep wake type
  - Shift work type
  - Unspecified
  - Jet lag type - removed



## CDP Treatments



- Melatonin Therapy
- Light Therapy
- Environmental Entrainment
- Consistent Bed-Wake Time





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## CDP Parasomnias

hjf 51

- ## CDP Parasomnias
- Non-Rapid Eye Movement
    - Sleepwalking type
    - Sleep terror type
  - Nightmares
  - REM Sleep Behavior Disorder
  - Restless Legs Syndrome
- hjf 52



## Somnambulism

- Up to 15 percent of adults occasionally get up and amble around the house in their sleep.
- Close relatives of sleepwalkers are 10 times more likely to sleepwalk than the general population.
- One study published in 2003 in the journal *Molecular Psychiatry* found that 19 percent of adult sleepwalkers had been hurt during their nocturnal forays.
  
- Treatment options
  - Time
  - Short-term benzodiazepine



## Nightmare Disorder

- Repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely dysphoric dreams, usually involving active efforts to avoid threats to survival, security, or physical integrity. The awakenings generally occur during the second half of the sleep period.
- On awakening from the dysphoric dreams, the person rapidly becomes oriented and alert (in contrast to the confusion and disorientation seen in Sleep Terror Disorder and some forms of epilepsy).
- The dream experience, or the sleep disturbance resulting from the awakening, causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The nightmares do not occur exclusively during the course of another mental disorder (e.g., a delirium, Posttraumatic Stress Disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.



## Discerning Between Sleep Events

- **Bad dreams** – relatively common, negative affect, person does not awaken from sleep
  
- **Night terrors** – individual is difficult to awaken, confused upon awakening, often inconsolable, partial-full lack of recall of event (often related to stress, medical problems)



## Discerning Between Sleep Events

- **Idiopathic nightmares** – awaken oriented, full recall of event, distressed, difficult to resume sleep
  
- **Post-trauma nightmares** – clear precipitating event, awaken oriented, usually terrified, often vivid recall of event (not always), difficult to resume sleep, often include gross body movements



## Nightmare Assessment Questions

- Did you have nightmares before the trauma?
- Did the nightmare awaken service member?
- How frequent are nightmares? Weekly?
- Which negative affect? Fear or anxiety?
  - Disgust, anger, sadness, guilt, frustration
- How severe are the nightmares?
- Have your nightmares changed over time?

O'Reilly, 2009



57



## How are PTSD nightmares different?

- Likely to be a replay of the traumatic event
- May occur earlier in the evening
- More likely to occur with gross body movements



58



## IRT Rationale

- Nightmares are a learned behavior
- With repetition, nightmares become automatic involuntary behaviors
- Nightmares can be reduced by replacing them with a more desirable behavior



59



## Imagery Rehearsal Therapy (IRT) overview

- Brief protocol
- Psychoeducation
- Relaxation training
- Monitor daily sleep activities for 1 week
- Breathing retraining/Relaxation techniques
- Restructure of nightmare
- Rehearse rescripted nightmare AND relax frequently



60



## Imagery Rehearsal Therapy

- Empirically supported for sexual assault survivors with PTSD
- Our data with **Vietnam** veterans less encouraging
- Pilot data with **OEF/OIF** veterans looks better
- Brief and generally well tolerated treatment for Chronic Nightmares
- Use of **Prazosin** in conjunction with IRT



## Recommended Reading

- Belenky G, Wesensten NJ, Thorne DR, et al. Patterns of performance degradation and restoration during sleep restriction and subsequent recovery: a sleep dose-response study. *J Sleep Res* 2003; 12:1–13.
- Perlis, M et al. Cognitive behavioral therapy for insomnia: A session by session guide. 2008. Springer Press
- Morin, C *Insomnia: A Clinician's Guide to Assessment and Treatment*. 2003. Springer Press
- Davis, J.L. (2009). *Treating Post-Trauma Nightmares: A cognitive-behavioral approach*. New York, New York: Springer Publishing Company.
- Thompson, K. E., Hamilton, M., & West, J. A. (1995). Group Treatment For Nightmares In Veterans With Combat-Related PTSD. *National Center for PTSD Clinical Quarterly* 5(4).



## Restless Leg Syndrome ([RLS](#))

- Neurological disorder leading to irresistible urge to move to stop uncomfortable sensations
- May affect other body parts
- Many individuals also report limb jerking during sleep



## Periodic Limb Movement ([PLM](#))

- Repetitive limb movements during sleep and is the only movement disorder that occurs only during sleep
- Often complain of excessive daytime sleepiness, fall asleep during day and have trouble maintaining sleep at night
- More common in people over age 65





## Medications for Insomnia

- Benzodiazepine agents approved by FDA

Drug	Half-Life (hours)	Absorption	Typical dose (mg)	Active metabolite
Halcion (triazolam)	2-5	Fast	0.125-0.25	No
Resertril (temazepam)	8-12	Moderate	7.5-30	No
ProSom (Estazolam)	12-20	Moderate	1-2	Minimal
Doral (Quazepam)	50-200	Fast	7.5-15	Yes
Dalmane (Flurazepam)	50-200	Fast	15-30	Yes



## Medications for Insomnia

- Nonbenzodiazepine agents approved by FDA

Drug	Half-Life (hours)	Absorption	Typical dose (mg)	Active metabolite
Sonata (zaleplon)	1-1.5	Fast	5-20	No
Ambien (zolpidem)	1.5-2.6	Fast	2.5-10	No
Ambien ER (zolpidem CR)	2.8	Fast	6.25-12.5	No
Tozerem (Ramelteon)	1-2.6	Fast	4-8	Yes
Lunesta (Eszopiclone)	6	Fast	1-3	Yes



## CDP Website: Deploymentpsych.org

### Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed



## Online Learning

The following online courses are located on the CDP website at:

<http://www.deploymentpsych.org/content/online-courses>

**NOTE: All of these courses can be take for free or for CE Credits for a fee**

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

*All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for \$350.*



## Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

### Features include:

- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.



## How to Contact Us

### Center for Deployment Psychology

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