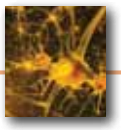

Cultural Competency and Treatment of Veteran and Military Patients With Mental Health Disorders

COL (Ret) Elspeth Cameron Ritchie, MD, MPH

About 2.5 million U.S. service members have served in conflicts since September 11, 2001. Estimates of the numbers of service members who have deployed to Iraq and Afghanistan and have posttraumatic stress disorder (PTSD) range from 15% to 25%.[1-3]

This special issue contains several excellent articles about PTSD and comorbidities, including insomnia and depression. Although there are service members who have pure PTSD, in the experience of most clinicians, that is the exception rather than the rule.[2] For example, insomnia may lead to patients' excessive drinking to try to sleep. Numbing and avoidance from the excessive drinking leads to relationship problems and often divorce. Relationship problems are subsequently a key driver of suicide.[4,5]

Also included in this issue is a series of articles examining the case study of William, who has multiple sclerosis (MS), a disease usually in the domain of neurologists, rather than psychiatrists. However, given the physical, cognitive, and social stresses of MS, it is not surprising that comorbid depression is extremely common, appearing in about half of patients with MS over their lifetime.[6] The multidisciplinary approach to care described in this series is critical for successful treatment.

There are well-established guidelines for the treatment of PTSD, developed by the American Psychiatric Association, DoD, and VA, often referred to as evidence-based treatments. However, there are many patients who are either unwilling or unable to adhere or who do not respond to the evidence-based treatments. Although these patients are often called treatment-resistant or refractory, it is also likely that the treatments are not engineered toward service members. That may be due to (1) unacceptable adverse effects from medication; (2) difficulties attending frequent appointments, especially for cognitive-behavioral treatments; (3) the reluctance of many service members to relive their trauma and/or talk about it; or (4) the stigma of seeking treatment.[2,7]

The physical stresses of military service, including wounds and injuries, involve corresponding pain and disability. Alcohol, depression, PTSD, and traumatic brain injury have long been associated with one another, but sometimes musculoskeletal injuries are left out of the discussion. The musculoskeletal issues have led to service members being treated with opiates, which can cause dependence and addiction.[4,5] In both military and civilian populations, many patients switch from legal opiates to illegal heroin. Many service members, especially after discharge from the military, thus start a slide into substance dependence, unemployment, and homelessness. Unfortunately, death by heroin overdose is increasingly common.[8]

Suicide rates among U.S. Army personnel have been increasing since 2004, surpassing comparable civilian suicide rates in 2008. The other service branches have not seen such a dramatic rise, but suicide is still a troubling problem. Suicide rates peaked in army active-duty troops over the past few years but are still rising in reservists. Suicides are most prevalent among young white males but have been increasing in older ages and females as well.[4,5]

Risk factors for suicide among active-duty members are well known, because data are systemically collected. These include relationship difficulties, financial and occupational problems, pain and physical disability, and access to weapons.[4,5]

CULTURAL COMPETENCY

The concept of moral injury is related to but different from PTSD, which is a medical diagnosis. In general, most authors conceptualize moral injury as an insult caused either by shame of killing or the guilt induced

Dr. Ritchie is a forensic psychiatrist. She most recently was the chief clinical officer at the department of behavioral health for the District of Columbia. She was formerly psychiatry consultant for Army Medicine.

when fellow service members die while one has survived. Although not well studied by the medical community, most agree that it is a corrosive condition, which contributes to relationship difficulties and suicide.

A theme throughout military medicine is one of cultural competency: If you are not in the military, how can you understand the military culture? As a start, one of the easy ways is for a provider to ask patients about their military occupational specialty, basic and advanced training, and where they have been stationed. Ask when and where they have been deployed. Learn what their military rank is/was, and ask how they want to be addressed. Some will prefer to be addressed by rank, others by their first name. An important piece of advice for providers: Combat veterans do not want to be seen as victims. Treat them as battle-hardened or maybe battle-scarred, and respect their service.

At present, 15% of active-duty military, 17% of National Guard/Reserves, and 20% of new recruits are women. The recent wars in Iraq and Afghanistan have engendered a growing population of female veterans seeking health care through VA. Thus, women are among the fastest growing segments of new users of VA health care: As many as 40% of women returning from Iraq and Afghanistan may elect to use the VA, for a variety of medical and mental health reasons. In the civilian world, women experience PTSD at twice the rate than do men. In the military, available statistics suggest that the rate is about the same.

There are certain occupations that may lead to an increased rate of PTSD. Medical staff are exposed to horrifically wounded service members and local populations. They and others may have been involved with detainee medical issues. In addition, many service members, including individual augmentees and other reservists, were assigned to detainee missions, such as at Guantanamo Bay and Abu Ghraib. In general, reservists may not have the support of a cohesive unit.

ADMINISTRATIVE ISSUES

Service members need to be physically and mentally fit for duty, according to various regulations.[9] If service members have a severe mental illness, they usually will receive a medical evaluation to assess whether or not they are fit for duty. Service members may be medically discharged if found not fit for duty. They may also be medically retired, depending on the severity of their condition, which carries significant disability benefits. The Medical and Physical Evaluation Boards, now called the Integrated Disability Evaluation System, is a complex process.[10]

The diagnosis of PTSD does not necessarily lead to a medical discharge. If service members respond to treatment, they may be found fit for duty. Alternatively, with actual practice varying according to the service branch, unfortunately they may be administratively discharged without benefits.

Service members may or may not want to be assessed by a Medical Evaluation Board, which offers both benefits and potential shame. Those who want to stay in the military, in general, do not want to see a mental health care provider, because they fear for their jobs. However, those who are nearing the end of their enlistment or planning to retire have many pressures to endorse PTSD symptoms. These include the financial benefits of medical retirement (often at 50% of their base pay), including free medical care and other benefits.

Military, VA, and other providers need to know how to diagnose and treat these psychologic and neurologic brain injuries and disorders. They also need to know when and how to refer elsewhere for further evaluation and treatment. Finally, because PTSD is very much in the public discourse, providers should be prepared to engage in a dialogue with the public. ●

REFERENCES

1. Tanielian T, Jaycox LH, eds. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: Rand Corporation; 2008.
2. Treatment of posttraumatic stress disorder in military and veteran populations. Institute of Medicine Website. http://www.iom.edu/Reports/2014/Treatment-for-Posttraumatic-Stress-Disorder-in-Military-and-Veteran-Populations-Final-Assessment.aspx. Published June 20, 2014. Accessed March 9, 2015.
3. Joint mental health advisory team VII (J-MHAT 7) report. U.S. Army Website. http://armylive.dodlive.mil/index.php/2011/05/joint-mental-health-advisory-team-vii-j-mhat-7-report. Published May 24, 2011. Accessed March 9, 2015.
4. Ritchie EC. Suicides and the United States army: Perspectives from the former psychiatry consultant to the army surgeon general. *Cerebrum*. 2012(2012):1.
5. Black SA, Gallaway MS, Bell MR, Ritchie EC. Prevalence and risk factors associated with suicides of Army soldiers. *Milit Psychol*. 2011;23(4):433-451.
6. Wallin MT, Wilken JA, Turner AP, Williams RM, Kane R. Depression and multiple sclerosis: Review of a lethal combination. *J Rehabil Res Dev*. 2006;43(1):45-62.
7. Hoge C. DSM-5 PTSD screening may miss previously diagnosed soldiers. Healio Website. http://www.healio.com/psychiatry/ptsd/news/online/%7B4e137bbf-4bc0-4c31-b6b2-77e83e9b09d9%7D/dsm-5-ptsd-screening-may-miss-previously-diagnosed-soldiers. Published August 25, 2014. Accessed March 10, 2015.
8. Rudd RA, Paulozzi LJ, Burleson RW, et al; Centers for Disease Control (CDC). Increases in heroin overdose deaths—28 states, 2010 to 2012. *MMWR Morb Mortal Wkly Rep*. 2014;63(39):849-854.
9. U.S. Army. *Standards of Medical Fitness, 2011*. Army Regulation 40-501. U.S. Army Website. http://www.apd.army.mil/pdffiles/r40_501.pdf. Published August 4, 2011. Accessed March 10, 2015.
10. Army Physical Disability Evaluation System. The army integrated disability evaluation system. U.S. Army Website. http://usarmy.vo.llnwd.net/e2/rv5_downloads/features/readyandresilient/ARMY_IDES.pdf. Accessed March 10, 2015.