PTSD, Depression and Suicide in Military, Veterans and Law Enforcement since 9/11; An American Perspective

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Outline

• A brief history, before and after 9/11
• Definition of PTSD
• PTSD in Soldiers and veterans
• PTSD and depression in law enforcement
• Therapies for PTSD
• Suicide
• Suicide in Soldiers and veterans
• Suicides in police officers
• Suicides by police (“suicide by cop”)
• Mental Illness and Violence
• Case Study
A Brief History of Psychological Reactions to War

- World War I--“shell shock”, over evacuation led to chronic psychiatric conditions
- World War II--ineffective pre-screening, “battle fatigue”, lessons relearned, 3 hots and a cot
- The Korean War---initial high rates of psychiatric casualties, then dramatic decrease

Principles of “PIES” (proximity, immediacy, expectancy, simplicity)
A Brief History of Psychological Reactions to War

• Vietnam War 1960s
  – Drug and alcohol use, misconduct
  – Post Traumatic Stress Disorder not yet defined

• Desert Storm/Shield
  – “Persian Gulf illnesses”, medically unexplained physical symptoms

• Operations Other than War (OOTW)
  – Combat and Operational Stress Control, routine front line mental health treatment
9/11 in Washington DC

- Beautiful clear fall day
- New York attack
- Pentagon burning
- Reports of bombs elsewhere
- Are We at War?
Combat Stress Control Principles Applied

• Proximity, Immediacy, Expectancy. Simplicity
• DiLorenzo Clinic at the Pentagon
  – Army, Air Force, Navy personnel operations for medical and mental health services
• -Groups
  – People more open to talk in workplace or at ‘coffee rounds’
Development of A Sustained Response

- Family Assistance Center
- Operation Solace
The Pentagon Family Assistance Center

• Tended to families of all victims

• The Sheraton in Crystal City
  – Extended family, children
  – Most lived there for up to a month

• Services
  – Informational briefings
  – Red Cross
  – Department of Justice, FBI
  – Counseling
  – Childcare
  • recreation
  – Medical care
  – DNA collection
The Pentagon Memorial at the Dedication
Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn

- Numerous stressors
  - Multiple and extended deployments
  - Battlefield stressors
    - IEDs, ambushes, severe sleep deprivation,
  - Medical
    - Severely wounded Soldiers, injured children, detainees
- Changing sense of mission
- Strong support of American people for Soldiers
- Major Focus of senior Army Staff
- Numerous new programs developed to support Soldiers and Families
The US Army since 9/11

• Volunteer Army
  – Know they are going to war
  – Seasoned, fatigued
  – Large Reserve Component
  – Reserve, National Guard
• Elevated suicide rate
• Wounded Soldiers
• Effects on Families
  – Continuous deployments
  – Families of deceased
  – Families of wounded
• Difficult Economy
Range of Deployment-Related Stress Reactions

• Mild to moderate
  – Combat Stress and Operational Stress Reactions (Acute)
  – Post-traumatic stress (PTS) or disorder (PTSD)
  – Symptoms such as irritability, bad dreams, sleeplessness
  – Family / Relationship / Behavioral difficulties
  – Alcohol abuse
  – “Compassion fatigue” or provider fatigue
  – Suicidal behaviors

• Moderate to severe
  – Increased risk taking behavior leading to accidents
  – Depression
  – Alcohol dependence
  – Completed suicides
PTSD DSM IV Diagnostic Concept

• Traumatic experience leads to:
  • Threat of death/serious injury
  • Intense fear, helplessness or horror  
    • (criterion A-2)

• Symptoms (3 main types)
  • Reexperiencing the trauma (flashbacks, intrusive thoughts)
  • Numbing & avoidance (social isolation)
  • Physiologic arousal (“fight or flight”)

• Which may cause impairment in
  • Social or occupational functioning

• Persistence of symptoms

\[ mTBI \text{ (mild Traumatic Brain Injury) may be associated with PTSD, especially in the context of a blast or other weapons injury} \]
DSM 5 Definition of PTSD

- Removes Criterion A-2
- Additional criteria
  - Somatic reactions
  - Sleep
  - Depressive symptoms
  - Anger and irritability
PTSD in Service Members

- Often accompanied by
  - Irritability
  - Anger
  - Pain
  - Substance abuse (usually alcohol)
  - Traumatic brain injury
    - Impulsivity
  - Other physical disabilities
PTSD in Police Officers

- Frequent trauma/critical incidents
- Very similar symptoms to service members
- Similar reluctance to admit/share issues
  - Worry about career
Major Depression

Depression is the most common serious mental condition.

Major Depression: This includes having one or more episodes that last at least 2 weeks where there is a very sad mood or the loss of interest in regular activities or interests.
Major Depression: SYMPTOMS

✓ Sad mood, “feeling dark, down all the time”
✓ Change in appetite
✓ Feeling tired, having low or no energy
✓ Feeling helpless, hopeless, or worthless
✓ Suicidal thoughts or actions
✓ Concentration problems
Traumatic Brain Injury (TBI)....
Behavioral Aspects of TBI

- Changes in cognitive abilities
- Poor impulse control
- Acting out behavior
Assistance

• Psychotherapy
• Medication
• Employee Assistance Program (EAP)
• Non-traditional support (complementary and alternative medicine)
  – Acupuncture
  – Therapy dogs
• Resiliency
  – Unit morale
Evidence Based Approaches for PTSD and Depression

• Psychotherapy
  – Cognitive behavioral therapy
    • Cognitive processing therapy
  – Prolonged exposure

• Pharmacotherapy
  – Antidepressants
    • SSRIs
    • Sexual Side effects
New and Innovative Approaches

• Pharmacotherapy
  – Second generation anti-psychotics
  – Sleep medications

• Integrative therapies
  – Acupuncture
  – Stellate ganglion block
  – Yoga, exercise
  – Canine therapy
  – Meditation and mindfulness
  – Art Therapy
  – Other

• Sexual health
How training service dogs addresses PTSD symptoms

**PTSD Symptom Clusters**

- Re-experiencing (B)
- Avoidance and Numbing (C)
- Increased Arousal (D)
Risk Factors Related to Suicidal Thoughts or Intentions; Civilian

• Making or changing a will
• Giving away prized possessions
• Putting personal or financial matters in order
• Conveying a sense of hopelessness about the future
• Threat or loss of primary therapist
• Rejection by family or significant other
Risk Factors for Suicide in US Army Personnel

• Usually young, white, male
• Major Psychiatric Illness Not a Significant Contributor
  – Adjustment disorders, substance abuse common
• Relationships
• Legal/Occupational Problems
• Substance Abuse
• Pain/Disability
• Weapons
  – 70% with firearm
• Recent Trends
  – Older, higher rank, more females
Suicide Risk Assessment

- Improve suicide assessment and evaluation
- Establish best clinical practices and standards of care
- Train behavioral health and medical care providers at all levels
- Improve engagement and retention in behavioral health care employing motivational interviewing techniques.
- Involve close family members and friends where ever possible.
- Inform and educate unit leaders as appropriate.
- Enhanced focus on postvention efforts (maintain vigilance post crisis), including cases of completed suicides.
Past Suicide Mitigation Approaches in the US Military

• Analysis of Incident Suicides
  – DOD Suicide Event Report (DODSER)
  – Epidemiologic Consultations (EPICONS)
• Clinical interventions to identify and treat high risk individuals
• Training Soldiers, Leaders and Family Members to recognize and respond
  – ASSIST
  – ACE
  – Battlemind
  – Beyond the Front
  – Stand-Down Training
Risk Factors for Suicide among Police Officers

- White, mid-30s, male
- Divorce or other relationship problem
  - Sometimes domestic violence
- Problem on the job
- Medical/disability
- Frequent trauma

Data
- 300 documented suicides in 1994, which is still often quoted
- Disputes about actual rate; often cited as double the normal population; others say that the rate is somewhat lower than equivalent white mid-30’s male
Suicide-by-police

• Also known as “death by cop”, “blue suicide”
• Most common scenario is pointing a firearm at a police officer or innocent person
  – Other weapons or provocative gestures
• Some will fire and/or kill others
• Aftermath often traumatic for police officers
• Research:
  – Of 843 police shootings, 50% were victim precipitated homicide (Parent, 2004)
  – Other data hard to obtain
Other Issues/Solutions

• Fire and Emergency Medical Services
• Targeting of police officers
  – Mentally ill individuals
  – Terrorist groups
• Hostage negotiation
  – Stockholm syndrome
• Crisis Intervention Officer (CIO training)
  – 40 hours of training on working with the mentally ill
The CIO Program includes...

- A forty-hour training for law enforcement officers
  - Basic info. about mental illnesses, recognizing signs and symptoms; public mental health system and local laws
  - Verbal de-escalation training and role-plays
  - Site visits to provider agencies & hospitals
  - Graduation and certification as a CIO (pin)

2013 CIO of the Year – M. Pulliam
Mental Illness and Violence

• It is true that persons with severe mental illness are more likely to be victims than aggressors
  – But recent high profile recent shootings have been by people with mental illness
• Mental illness Risk factors for violence
  – Delusions
  – Paranoia
  – Irritability
  – Substance abuse
  – First evidence psychosis
You receive a call from a man who is concerned about his son. The son returned six months ago from Afghanistan and was discharged from the Army. Since then he has not been able to find a job. According to his father, he is now holed up in the basement of the family’s home, possibly with a rifle. He has a history of PTSD, mild traumatic brain injury and has been drinking heavily. What do you do?
Questions/Discussion

Combat and Operational Behavioral Health
www.bordeninstitute.army.mil
Women at War

Edited by Elspeth Cameron Ritchie and Anne L. Naclerio

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ABOUT THE BOOK

Women at War reviews the epidemiology, changes in policy, and demographics of women in the services; the factors affecting their health and health care while serving in austere environments; issues related to reproductive and urogenital health; and how health care providers can help prepare and prevent illness.

Readership: Primary care clinicians, physicians, nurse practitioners.
Causal Factors for Violence Among Soldiers

- Multiple individual, unit, and community factors appear to have converged to shift the population risk to the right

**Facts**

**Individual**
- Criminality/Misconduct
- Alcohol / Drugs
- BH Issues (untreated/under-treated)

**Unit**
- Turnover
- Leadership (Stigma)
- Training / Skills

**Environment**
- Turbulence
- Family Stress / Deployment
- Community
- Stigma
Strategies to Decrease Violence

- While it is important to identify and help individual Soldiers, the biggest impact will come from programs that shift the overall population risk back to the left.
- Effective medical treatment can prevent individuals from increasing in risk or decrease their risk, but it cannot shift overall population risk very much.

**Army Campaign Plan:**
- Health Promotion, Risk Reduction, and Suicide Prevention
- Increase Resiliency
- Decrease Alcohol/Drug Abuse
- Decrease Untreated/Undertreated BH
- Decrease Stigma to Seeking Care
- Decrease Relationship/Family Problems
- Decrease Legal/Financial Issues

**Installation:**
- Reintegration (Plus)
  - Mobile Behavioral Health Teams
  - Mental Toughness Training
  - Resiliency Training
  - Military Family Life Consultants
  - Decompression Reintegration
  - Warrior Adventure Quest
- Consistent Stigma Reduction themes