TIER 2 DAY 2

Center for Deployment Psychology
Uniformed Services University of the Health Sciences

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

Ethical Considerations for Working with Military Members and Veterans

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.

Learning Objectives

1. Define ethics as it relates to the role of the mental health provider.
2. Identify five (5) ethical challenges common to mental health providers working with the military population.
3. Discuss Gottlieb's model for avoiding dual relationships.
4. Demonstrate knowledge of the ethical decision making process through interactive discussion of military case examples during the presentation.

What is Ethical

The Martian Agency (2010)

Why Ethics?

We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly.

- Aristotle, 384-322 B.C., Greek philosopher and scientist, student to Plato

Even the most rational approach to ethics is defenseless if there isn't the will to do what is right.

- Alexander Solzhenitsyn, Author, winner of the 1970 Nobel Prize for Literature

You WILL be exposed to ethical dilemmas

Questions about Ethics

Values are like fingerprints. Nobody's are the same, but you leave 'em all over everything you do.
— Elvis Presley

(DoD photo by Mass Communication Specialist 3rd Class Jasmine Sheard, U.S. Navy/Released)

What are Ethics?

U.S. Navy photo by Chief Mass Communication Specialist Tiffini Jones Vanderwyst/Released

Ethics?

Merriam Webster's Dictionary offers the following definitions

Ethics:

1. A treatise on morals. 2. The science of moral duty; broadly, the science of ideal human character. 3. Moral principles, quality, or practice.

Ethical:

1. Of or relating to moral action, motive, or character; also, treating of morals, or ethics. 2. Conforming to professional standards of conduct.

But as an action…

- Thinking about reasons in terms of values in a manner that is open to public scrutiny

Ethics

- Therapists must integrate their personal ethical and value traditions with psychology's
- Two major variables:

1) Maintenance refers to the degree that we retain the ethical and value traditions of our culture of origin

2) Contact and participation refers to the degree to which new psychologists adopt the traditions, norms, values of their new professional culture

Handelsman et al (2005) in Gottlieb et al (2008)

Ethics Standards Are Not Enough

Principle ethics*:* Obligations to consider when deciding "what to do."

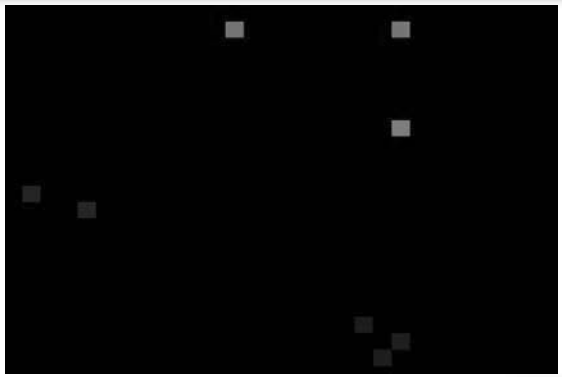
Virtue ethics: Ideals to consider when deciding "who shall I be?"

Principle A: "Psychologists strive to benefit those they serve and take care to avoid harm."

Never let your sense of morals prevent you from doing what's right.
— *Isaac Asimov*

Meara et al (1996)

Is It Ethical?



Campbell et al. (Writers), & Leddy (Director) (2001)

Ethics Standards Are Not Enough

A Psychologist with virtues and principles is one who is:

- •Motivated to do good
- •Possesses vision and discernment
- •Emotionally intelligent
- •Self-aware
- •Appreciates and respects community mores in decision-making

You can easily judge the character of a man by how he treats those who can do nothing for him.
— James D. Miles

Ethics Continued: Profession Specific

- •General Principles: are considered aspirational in nature and are intended to be considered when confronting ethical dilemma's
- •Ethical Standards: are purposely written broadly to apply to psychologists in varied roles and the particular application of a standard can vary depending on the context
- •Ethics must be practical:
  - ➢ "Every clinician is unique – every client is unique."
  - ➢ "Ethics that are out of touch with the practicalities of clinical work… are useless."

Pope & Vasquez (1998) in Barnett et al (2007)

Dilemma vs. Conflict

U.S. Navy photo by Mass Communication Specialist 2nd Class Michael Russell/Released

What is it?

Ethical Dilemma

An ethical dilemma is a situation in which conforming to professional standards of conduct creates a need to make a choice between equally unsatisfactory alternatives. This often results from a discrepancy between professional ethics and law or institutional policy.

Ethical Conflict

For an ethical–legal discrepancy to become a conflict, the provider's obligations under the law and the provider's obligations under his or her professional code of ethics must be mutually exclusive.

Johnson et al (2010), pg. 549

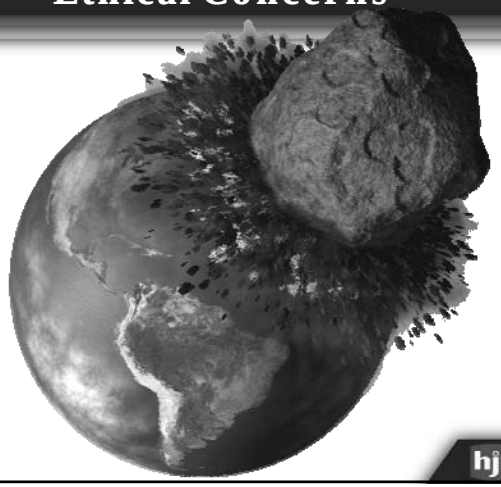
Conflict: DoD Policy and APA Ethics Code

Psychologists in a military setting face challenges with informed consent:

- Military mission
- Who is the client?
- The impact on the SM's career

Strategic Model for Managing Ethical Concerns

"Hope is not a plan"



Forensic Psychology Ethical Decision Making Model

1. Identify the problem
2. Consider the significance of the context and setting
3. Identify and utilize ethical and legal resources
4. Consider personal beliefs and values
5. Develop possible solutions to the problem
6. Consider the potential consequences of various solutions
7. Choose and implement a course of action
8. Assess the outcome and implement changes as needed

Bush et al (2006)

Considerations for Discussion

I. Boundaries of Competence

II. Informed Consent

III. Disposition Driven Diagnosis

IV. Multiple Relationships

V. Professional's Own Fitness

American Psychological Association (2010)

I. Boundaries of Competence

•This is a unique population with its own cultural identity. Is the therapist aware of this culture?

•Is the therapist trained to treat problems and disorders common to military members and veterans?

•Standard 2.01 (Boundaries of Comp.)

•Standard 2.02 (Emergencies)

American Psychological Association (2010)

Boundaries of Competence

- Military Culture
  - Language
  - Demographics
  - Rank and organizational structure
  - Manners and normative behaviors
  - Beliefs, mission, and values

Luby (2012), Reger et al (2008)

Increase Military Cultural Competency

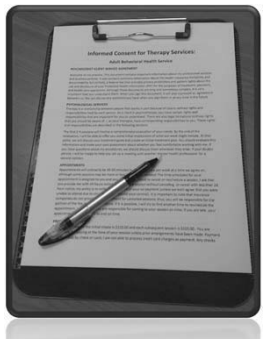
I. Make a Self Inventory
II. Adapt Care to Military Culture
III. Attend Military Activities
IV. Increase Off-Post Social Support

I. Exposure to Military Culture
II. Training on Military Regulations
III. Training Through Observation

Luby (2012), Reger et al (2008)

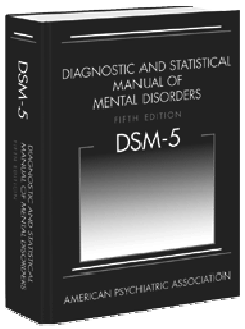
Boundaries of Competence: The Marine Case #1

II. Informed Consent



Informed Consent:
The National Guard Student
Case #2

III. Disposition Drives Diagnosis



Problems with Administratively Driven Diagnoses

> "Psychologists base the opinions contained in their recommendations, reports, and diagnostic evaluative statements on information and techniques sufficient to substantiate their findings."
>
> APA (2010)

Problems with Administratively Driven Diagnoses

- The "psychologist as administrative broker" role can have unintended consequences for service members.
  - Can perpetuate view of psychologists and mental health diagnosis as imprecise and psychiatric disorders as meaningless or silly.
  - Can also can lead to increased stigma for seeking treatment and devaluing of psychological services

Problems with Administratively Driven Diagnoses

We are ethically obligated to provide correct diagnosis no matter how the chips fall…

- "My wife says she will leave me/I will lose my job if I have to deploy again."
- "I have to go home right now to save my marriage."
- "Is it really MDD?"

Hot-Button Issues

- Can create lots of tension between the patient and the military with conflicting goals for each side
- Can be popular diagnoses that get lots of attention in the media and may be misunderstood or stereotyped in popular culture

Hot-Button Issues

- Substance abuse
- PTSD
- Suicidal behavior
- Who is the client
- Implications of diagnoses
- How do you balance the following:
  - Potential secondary gain
  - Stigma
  - Barriers to care
  - Confidentiality

Disposition Drives Diagnosis:
"Off the Record"
Case #3

IV. Multiple Relationships

- Military members can often present opportunities to create dual relationship.
- You must approach them carefully and thoughtfully.

Multiple Relationships

Multiple Relationships occur when a psychologist:

- Has more than one role with a client
- Has a relationship with a person closely associated with the client
- Is likely to enter into another relationship with the client in the future

American Psychological Association (2010)

Gottlieb's Five-Step Model for Avoiding Dual Relationships

Step 1. Assess the current relationship according to three dimensions:

1. Power of provider in the relationship
2. Duration of the existing relationship
3. Termination is clearly defined and definitive

Step 2. Look at the contemplated (dual) relationship from the three dimensions.

If these three dimensions are all high, the relationship should be avoided because there is risk for harm (high therapist power, long term relationship and no clear/specified termination).

Gottlieb (1993)

Gottlieb's Five-Step Model for Avoiding Dual Relationships

Step 3. When the three dimensions fall in the mid-range, examine both relationships for incompatible roles.

Step 4. Obtain consultation from a colleague.

Step 5. Discuss the decision with the consumer/patient.

Dual relationships may be even more complicated for military providers working at a military treatment facility

Gottlieb (1993)

Multiple Relationships: Petty Officer 3rd Class Case #4

V. Professional's Own Fitness

Professional's Own Fitness Personal Problems & Conflicts

Standard 2.06

- Psychologists refrain from activities when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
- When impaired, they take appropriate measures to obtain professional help and determine whether they should limit or suspend practice.

American Psychological Association (2010)

Professional's Own Fitness
Personal Problems & Conflicts

- Exposed to stories of human suffering, war and death
- Accountable to engage in self-assessment
- Accountable to seek assistance
- Accountable to scrutinize the fitness of colleagues
- Any difficulties here?

Professional's Own Fitness:
Skipping Lunch and Scrambling
Case #5

Ethics in Action

Alda et al (Writers) & Alda (Director) (1983)

Ethics in Action

Alda et al (Writers) & Alda (Director) (1983)

A Reminder

•Standard 1.02: Conflicts between Ethics and Law, Regulations, or other Governing Authority.

If psychologist's ethical responsibilities conflict with law, regulations, etc., psychologists make known their commitment to the Ethics Code…If the conflict is irresolvable, psychologists **may** adhere to the requirements of the law…

Remember to be vigilant of self and other providers to ensure ethical and safe practice.

American Psychological Association (2010)

Key Points

Examine several models for anticipating and responding to ethical dilemmas:

- •Utilize a structured decision making model
- •Talk to peers/colleagues
- •Have a list of experts for consultation
- •Document discussions & actions
- •Be mindful of behavioral drift
- •Decision-making in ethics always involves a process
  - •This process involves thinking about values
- •Good law, good ethics, and good clinical care go hand-in-hand
- •Never worry alone

Summary

- •Personal/professional ethics
- •The decision-making process
- •Strategies for anticipating and responding to ethical dilemmas
- •Ethical dilemmas encountered by clinicians working with military members and veterans
- •How the APA Ethics Code may conflict with DoD regulations, law and/or policy

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's website at:
Deploymentpsych.org/training/online-courses

NOTE: All of these courses can be taken 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 cover topics including:

- 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

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Ethical Considerations for Working with Military Members and Veterans — Case Studies

Boundaries of Competence:
The Marine
Case #1

You are one of two civilian psychologists working in a local clinic in a small town with no nearby military treatment facilities or VA clinics. Neither you nor the other provider have prior experience treating service members. A client is referred to you who is a 28-year-old, divorced, Caucasian male. The intake notes from the referral indicate that he was a Marine for 9 years with three combat deployments: two for OIF in 2007 and one for OEF in 2009. According to the intake notes, his divorce was finalized last year; he had his second DUI last month; and during deployment, several of his buddies were killed in combat when their vehicle blew up, which he witnessed, and another buddy completed suicide during the past year. Based on the intake notes the client denied any suicidal ideation but reported complaints that could suggest PTSD like nightmares, bouts of irritability, disturbed sleep, avoidance of reminders of his buddies' deaths, seeing images of the burning vehicle, and feeling "numb" and disconnected from others.

Informed Consent:
The National Guard Student
Case #2

You are a civilian social worker in a university counseling center treating a 20-year-old, Caucasian female in the National Guard. She entered counseling because of disciplinary measures stemming from an underage drinking ticket, her first legal complication. In your third session, you learn that she is scheduled to deploy in support of Operation Enduring Freedom (OEF – Afghanistan) after the semester. In the intake, she had indicated that she drinks regularly with her friends (mostly weekends), and that she has blacked out several times at football tailgate parties. During this session, when you ask her more about her National Guard experience and what her MOS (job) is, she tells you she is qualified to drive trucks and will likely be driving outside the wire delivering supplies as part of a convoy. She states that she has good friends in the National Guard, and that she drinks with them when she can.

Disposition Drives Diagnosis:
"Off the Record"
Case #3

You are a psychologist in private practice and accept Tri-Care. You have an appointment with a 23-year-old, single, African American male who is a four year Army veteran. He states he recently separated from the Army in order to go to school, but that he intends to re-enter the military and attend Officer's Candidate School (OCS) when he completes his degree. He is hoping to have a 20-year military career and to be in Special Forces. He denies any history of psychiatric treatment, but indicates that he is seeking your assistance because he has periods of time when he rarely sleeps and yet can be incredibly productive during these times; recently he has been able to read ahead of his classmates, and when in the Army he "never slept much anyway." However, he has been getting into fights recently. Also, his girlfriend broke up with him after he drove to Alabama (a 2-day drive) to see an Army buddy that he wanted to have a beer with. He's speaking very quickly and his stories can be tangential, but he can be redirected when asked direct questions. During the interview, he interrupts himself to say, "By the way, I don't want you to write anything in the notes. I just have to talk this stuff out. I came to you so that this wouldn't go into my record. That's why I'm going to pay you in cash." He explains that he won't be using his Tri-Care benefits.

Multiple Relationships:
Petty Officer 3rd Class
Case #4

You are a Military OneSource Provider in a city near a large Naval base. One of your patients is a 34-year-old, Asian American Lieutenant Commander JAG (Naval lawyer), whom you are seeing for mild depression and anxiety related to work stress. Another of your patients is a 22-year-old Caucasian female Petty Officer 3rd Class (PO3) who is experiencing distress regarding a history of childhood abuse and a recent military sexual assault, which she has not reported to legal services. One day, the JAG calls you and tells you that he is calling as the legal representative for his command, which is also the command of the PO3. He says that the PO3 was hospitalized last weekend after a breakdown on her ship in which she threatened to kill herself or someone else. He says the hospital psychiatrist recommended she be administratively separated for a personality disorder. The JAG tells you that he is handling this case and that the PO3 is fighting the separation. She has requested a formal hearing (administrative separation board) and asked him to contact you to confirm her earlier report of sexual assault. She has also requested you testify at the separation board.

Professional's Own Fitness:
Skipping Lunch and Scrambling
Case #5

You are a therapist working for at a local women's health clinic. You have become reputable as one of few providers in the area and one who successfully treats women with symptoms related to military sexual trauma. You find yourself skipping lunch, staying at work late to finish notes, avoiding exercise because you are so exhausted, and grimacing frequently with back pain. Every once in a while, you have trouble focusing on your clients during sessions. Twice a week you scramble to make it to an evening class on treating eating disorders in women- an area you are less familiar with but encounter in the clinic - because this seminar is rarely offered where you live. Today you had to leave work early when your 15-year-old niece who is staying with you for the summer called because she had gotten in a car accident.

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

Assessment and Treatment of Depression and Suicidal Behavior Associated with Military Service: An Overview

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.

Learning Objectives

1. Discuss the prevalence of depression and suicide in the military population.
2. Describe the correct nomenclature for suicidal and related behaviors.
3. Identify strategies for screening and assessing military clients for depression and suicidal behaviors.
4. Review effective therapies for treating military clients with depression and those displaying suicidal behaviors.

- What are your negative thoughts about seeing suicidal clients in general?
- What are/could be the hardest parts about working with suicidal military or veteran clients?

Outline

- Military depression and suicide rates
- Etiology of depression and suicide
- Depressive Spectrum Disorders: diagnostic criteria
- Suicide risk factors, warning signs & protective factors
- Assessment of depression and suicide
- Treatment of depression and suicidal behavior

Military Health Significance of Depression and Suicide

Depression in Returning OIF/OEF Service Members

12 Month Post-Deployment	Depression Symptoms	Depression Symptoms/ Some Impairment	Depression Symptoms/ Functional Impairment
Active Component	15.7%	14.4%	8.5%
Reserve Component	15.9%	13.7%	7.3%

Thomas et al. (2010)

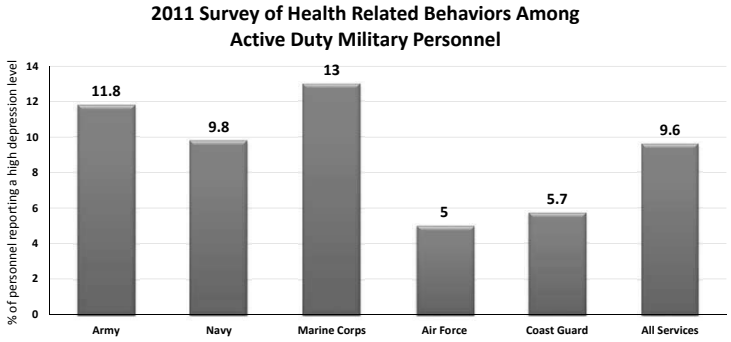
Depression and Deployment in Millennium Cohort Study

New Onset Depression

	Men	Odds Ratio	Women	Odds Ratio
Never Deployed	3.9%	1.0	7.7%	1.0
Deployed, No Combat	2.3%	**.66**	5.1%	**.65**
Deployed, Combat	5.7%	**1.32**	15.7%	**2.13**

Wells et al. (2010)

2011 DoD Survey: Level of Depression



DoD 2011 Health Related Behaviors Survey (2013)

Depression in Veterans

- 14% of veterans are diagnosed with depression
  - –Yet it is likely under-diagnosed
- 11% of veterans aged 65+ y/o are diagnosed with MDD (twice the rate of adults 65+ in the general population)

National Alliance on Mental Illness (2009); U.S. Department of Veterans Affairs

Suicide >

Homicide or War-Related Deaths

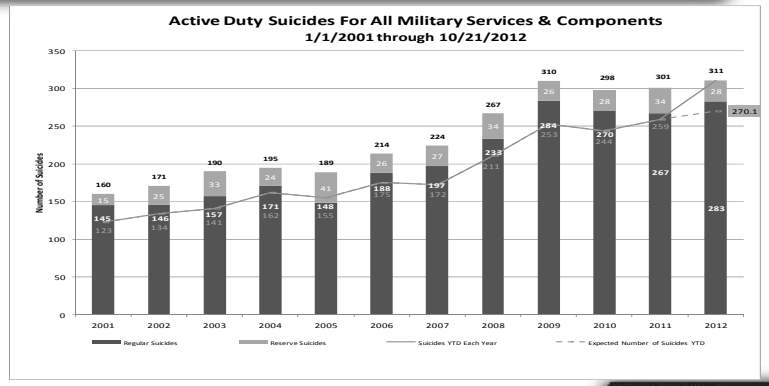
Public domain image courtesy of Wikipedia

Every year…

Globally	Nationally
Almost 1 million suicides	Steady rise since 2000
16 per 100,000	12.3 per 100,000
1 every 40 seconds	1 every 13.3 minutes

World Health Organization (2013); American Foundation for Suicide Prevention; Reza et al. (2001)

DoD Suicide Deaths by Component and Calendar Year



Mortality Surveillance Division, Armed Forces Medical Examiner

DoD Suicides & Suicide Rates by Service: Active Component

	All Services	Air Force	Army	Marine Corps	Navy	General Population (CY 2013)
Total Count	259	48	123	45	43	41,149
Rate/ 100K	18.7	14.4	23.0	23.1	13.4	13.0

Smolenski et al. (2014); Centers for Disease Control and Prevention (2014)

DoD Suicides & Suicide Rates by Service: Selected Reserve

	All Reserve	Air Force Reserve	Army Reserve	Marine Corps Reserve	Navy Reserve	All National Guard	Air National Guard	Army National Guard
Total Count	87	12	60	11	4	133	14	119
Rate/ 100K	23.4	--	30.1	--	--	28.9	--	33.4

Smolenski et al. (2014)

Veteran Suicide Rates

Approx 22% of US suicides each year are veterans

On average, 22 veterans die by suicide each day

U.S. Army photo by Adam Skoczylas

Kaplan et al. (2009); Kemp & Bossarte (2013)

Veteran Suicide Rates

Male and female veterans had higher firearm suicide rates than nonveterans

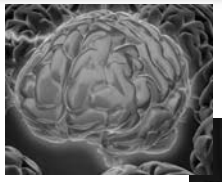
DoD photo by Sgt. Michael J. MacLeod, U.S. Army

Kaplan et al (2009)

Etiology of Depression and Suicide

Why Do Some Service Members Develop Depression?

- Physiological
  - Genetics
  - Biological factors
  - Substance abuse
- Psychological
  - Learned helplessness/hopelessness
  - Cognitive factors/Irrational thought processes
- Environmental
  - Loss of loved one
  - Social withdrawal
  - Stress



U.S. Army photo by Ian Graham.

Warriors See the World Differently

Photo: Afterdeployment.org

Mental Health Culture vs. Military Culture

Traditional MH Culture

- Individualistic; 1-on-1 approach
- Emotional vulnerability
- Treatment is delivered individually
- Assumes deficiencies/illness
- Symptoms & risk factors

Military Culture

- Collectivist; in-group identity
- Emotional toughness
- Leaving group for help jeopardizes safety
- Assumes elitism/strength
- Warrior skills & assets

Bryan (2010)

Military Myths about Depression

I don't need help because …

- Only weak people get depression
- My depression will go away if I wait it out
- Treatment does not work

U.S. Marine photo. No photographer cited.

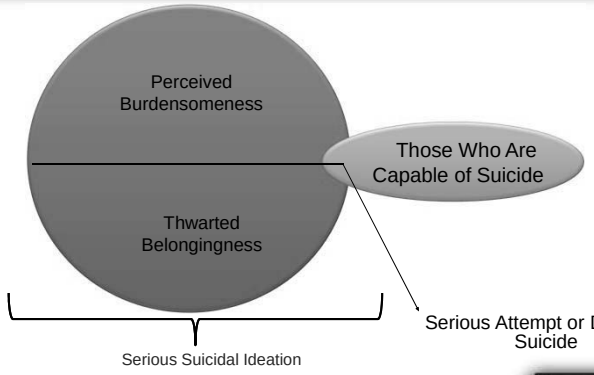
If I seek help …

- Everyone in my unit will know
- I will lose the trust of my unit
- I will lose my leadership role
- I will lose my security clearance
- My career will be hurt
- I will be administratively/medically separated

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

Why Do Some People (including Service Members and Veterans) Die by Suicide?

Interpersonal-Psychological Theory of Suicide Risk



Joiner (2005)

2 Most Significant Contributors to Suicidal Ideation

✓Thwarted belongingness

✓Perceived ineffectiveness/burden

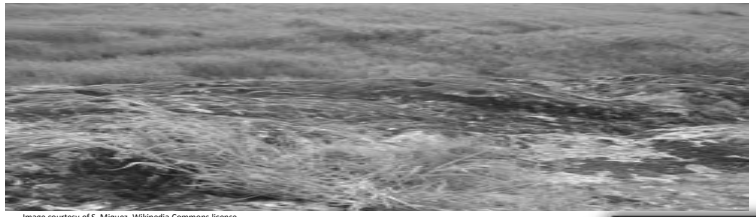


Image courtesy of S. Miquez. Wikipedia Commons license

Joiner (2005)

Thwarted Belongingness

Need:

1. Frequent interaction w/ others
2. Persistent feeling of being cared about

Interactions must be frequent and positive

Joiner (2005)

Perceived Ineffectiveness/Burden

Feeling ineffective, plus the sense that loved ones are threatened or burdened by this ineffectiveness.

Joiner (2005)

Acquired Ability

Reduction of fear through repeated self-injury is necessary for serious suicidal behavior to occur (can occur in the short term or over the long term)

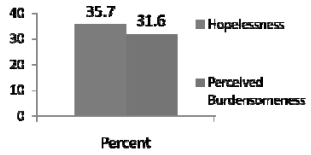
1. Previous suicidal behavior
2. Any experience that reduces fear of injury

Public domain images from DEA

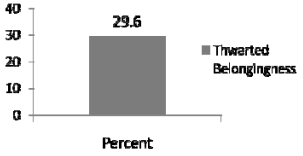
Joiner (2005)

Empirical Support for IPT in Military Populations

- Suicide note communication
  - Hopelessness
  - Perceived burdensomeness



- Verbally and through suicide note
  - Thwarted belongingness



Cox et al. (2011)

Depressive Spectrum Disorders: Diagnostic Criteria

DSM-5: Spectrum of Depressive Disorders

- **Major Depressive Disorder**
- **Persistent Depressive Disorder (Dysthymia)**
- **Premenstrual Dysphoric Disorder**
- **Substance/ Medication-Induced Depressive Disorder**
- **Depressive Disorder Due to Another Medical Condition**
- **Other Specified Depressive Disorder/ Unspecified Depressive Disorder**

American Psychiatric Association (2013)

DSM-5: Major Depressive Episode

5 or more of the following for a 2-week period (at least one*):

(1) depressed mood most of the day*
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day*
(3) significant weight loss/gain or decrease or increase in appetite
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt
(8) diminished ability to think or concentrate, or indecisiveness
(9) recurrent thoughts of death, suicidal ideation

American Psychiatric Association (2013)

Adjustment Disorder with Depressed Mood

- In DSM-5, this diagnosis falls under Trauma-and Stressor-Related Disorders not Depressive Disorders
- If an individual has symptoms meeting criteria for a major depressive disorder in response to a stressor, the diagnosis of adjustment disorder does not apply

Trauma and Depression

- Trauma reactions do not *only* include PTSD
- PTSD and depression symptoms overlap, and co-morbidity rates are high
- Some military personnel join the service with a history of depression and/or trauma
- Depression may develop that is not related to deployment or a traumatic event

Tanielian & Jayacox (2008)

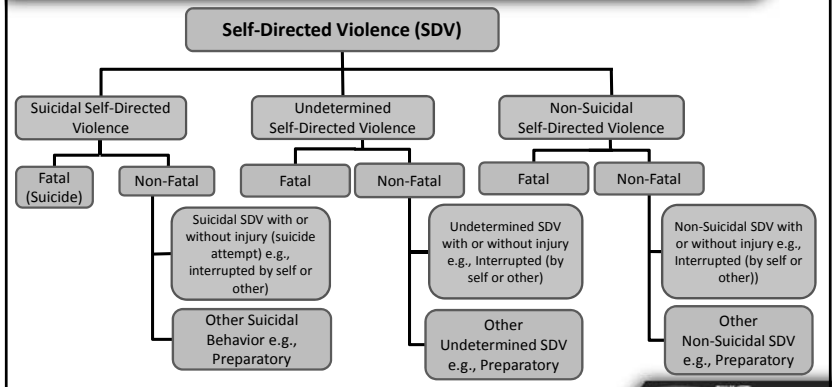
Nomenclature For Suicidal And Related Behaviors

SDV Terminology

- Self-Directed Violence (SDV) Classification System
  - Collaborative approach between the Centers for Disease Control and the VISN 19 MIRECC
  - Describes *thoughts* and *behaviors* associated with suicidality
  - Modifiers exist to address the following:
    - Intent (with, without, or undetermined)
    - Injury (with, without, or fatal)
    - Interrupted act (by self or others)

Brenner et al (2011), Crosby et al (2011)

Flowchart for Self-Directed Violence Definitions



Brenner et al (2011), Crosby et al (2011)

Self-Directed Violence Nomenclature: Thoughts

Type	Definition	Modifiers
Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.	None
Suicidal Ideation	Thoughts of engaging in suicide-related behaviors.	▪ Suicidal Intent: - Without - Undetermined - With

Brenner et al. (2011)

Self-Directed Violence Nomenclature: Behaviors

Type	Definition	Modifiers
Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method or preparing for one's death by suicide.	• Suicidal Intent: -Without -Undetermined -With
Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.	• Injury: -Without -With -Fatal • Interrupted by Self or Other

Brenner et al. (2011)

Self-Directed Violence Nomenclature: Behaviors

Type	Definition	Modifiers
Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence.	• Injury: -Without -With -Fatal • Interrupted by Self or Other
Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.	• Injury: -Without -With -Fatal • Interrupted by Self or Other

Brenner et al. (2011)

Suicide Prevention

Shoulder to Shoulder: Finding Strength and Hope Together

Army Suicide Prevention Program (2011)

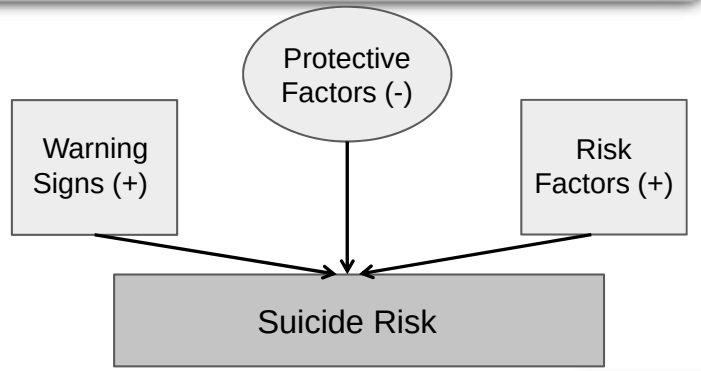
Goal of Suicide Prevention and Treatment

Protective Factors

Risk Factors

Risk Factors, Warning Signs & Protective Factors

Conceptual Model of Suicide Risk



Cornette, M. (2013)

Suicide Warning Signs

- **I** – Ideation
- **S** – Substance Abuse

- **P** – Purposelessness
- **A** – Anxiety
- **T** – Trapped
- **H** – Hopelessness

- **W** – Withdrawal
- **A** – Anger
- **R**– Recklessness
- **M** – Mood Changes

DoD photo by Staff Sgt. Trey Harvey, U.S. Army released.

See handout: "How do you Remember the Warning Signs of Suicide"

Rudd et al. (2006c); American Association of Suicidology (2012)

Suicide Risk Factors

- More distal in nature than warning signs
- More static in nature than warning signs
- Some risk factors are modifiable/some are not
  - See handout: "Risk Factors for Suicide and Suicidal Behaviors"

American Association of Suicidology (2012)

Military Suicide Risk Factors

- Relationship problems
- Hopelessness/worthlessness
- Alcohol abuse/dependence
- Feelings of disgrace/isolation
- Guilt or shame
- Stressful military life events
- Easy access to firearms
- Unexplained mood change/depression
- Financial, legal or job performance problems
- Medical or administrative discharge processing
- Sleep problems
- Previous suicide attempts **

Martin et al. (2009); Jones et al. (2012); Ribeiro et al. (2012); Bryan et al. (2013)

Sleep: Active Duty

Sleep problems outperformed depression and hopelessness as predictors of suicidal ideation and behavior in young adults in the military

U.S. Marine Corps photo by Cpl. Alejandro Pena.

Ribeiro et al. (2012)

Mental Health Diagnoses and Treatment History: Veterans

Top mental health diagnostic contributors to suicide risk among VA patients:

1. Bipolar disorder
2. Substance use disorders
3. Depression
4. Anxiety disorders other than PTSD

Ilgen et al. (2012)

TBIs: Active Duty

Multiple TBIs were associated with a significantly higher risk for suicide, even after controlling for symptom severity

Bryan & Clemens (2013)

Traumatic Brain Injury (TBI): Veterans

- VA patients w/ TBI history 1.55 times more likely to die by suicide than those without
- Among psychiatric inpatients with TBI histories, 27.3% had made a total of 14 suicide attempts

U.S. Army photo. Photographer not listed.

Brenner et al. (2011); Gutierrez et al. (2008)

Chronic Pain: Veterans

* Increased risk for suicidal ideation and suicide attempts has been found in individuals with chronic pain, particularly head pain and pain classified as “other non-arthritic”

Juurlink et al. (2004); Fishbain et al. (2009); Ilgen et al. (2008)

Military Suicide Protective Factors

- Social support or sense of belonging
- Leadership responsibilities
- Effective coping and problem-solving
- Unit cohesion
- Access to assistance services
- Healthy lifestyle promotion
- Spiritual support
- Policies/culture that encourage help-seeking

Martin et al. (2009); Jones et al. (2012); Bryan & Hernandez (2013)

Assessment of Depression and Suicide

What Do Depressed or Suicidal Service Members Look Like?




Case Study: Assessing Mood

Case Study: Assessing Other Depressive Symptoms

What Depression and Suicide Assessment Tools Do You Use?

Self-Report Screens/ Measures of Depressive Symptoms

Incorporate self-report measures:

- PHQ-2 Symptom Checklist = 2 items
- PHQ-9 Symptom Checklist = 9 items
- Center for Epidemiological Studies (CES-D) = 20 items
- Beck Depression Inventory-2 (BDI-2) = 21 items
- Zung Depression Scale = 20 items
- Hamilton Depression Rating Scale = 17 to 31 items

Management of Major Depressive Disorder Working Group (2009); Beck et al. (1996); Carroll et al. (1973); Hamilton (1980); Radloff (1977); Zung (1965)

Self-Report Measures of Suicidal Ideation/Behavior

- Beck Scale for Suicidal Ideation
  - BSS; Beck & Steer (1991)
- Suicide Intent Scale
  - SIS; Beck, Schuyler, &Herman (1974a)
- Beck Hopelessness Scale
  - BHS; Beck et al. (1974b)
- Suicidal Behavior Questionnaire-18
  - SBQ-18; Linehan (1996)
- Suicidal Behavior Questionnaire-Revised
  - SBQ-R; Osman et al. (2001)

Beck, Schuyler, & Herman (1974a); Beck, et al. (1974b); Beck & Steer (1991); Linehan (1996); Osman, et al. (2001)

Suicide Risk Assessment

- Previous suicidal behavior
- Current suicidal thoughts, intent, and behavior
- Precipitant stressors (acute and chronic)
- General psychiatric symptoms
- Impulsivity and self-control
- Risk and protective factors
- Use of medications or substances
- Hopelessness
- Warning signs
- Access to lethal means

Department of Veterans Affairs/Department of Defense (2013); Rudd (2006)

Suicide Risk Assessment (cont.)

- Gain a complete understanding of medical, social and mental health history
- Utilize empirically supported suicide risk assessment instruments in conjunction with a clinical interview
- Obtain collateral information from family, friends, unit, commander, and medical
- Use a direct/nonjudgmental/collaborative approach

Assess risk on an ongoing basis

Department of Veterans Affairs/Department of Defense (2013)

Fluid Vulnerability Theory

- Views suicide risk on a continuum
- Acute risk vs. chronic risk
  - Baseline risk - based on personal history, static factors
  - Acute risk - superimposed upon baseline risk
- Suicidal episodes are time limited
- Acute risk resolved when risk factors are effectively targeted

Rudd (2006b)

Assessing Risk Through Clinical Interview

Assess Baseline Risk

Assess for chronic risk

- Present or absent based on history of multiple attempts

Based on personal history and stable factors

- For example, history of abuse, history of attempts, psychiatric diagnosis

Assess Acute Risk

Reflects the current crisis and overall risk

Exists on a continuum

Time-limited periods of heightened vulnerability to suicide

Includes dynamic factors

- Nature of suicidal thinking, intent, and symptom presentation

Will fluctuate in severity as the suicidal crisis resolves

Rudd (2006a)

Assessing Risk
Continued

Acute Risk – Points to Remember

Being thorough does not take a lot of time

Use precise terminology

- Differentiate between non-suicidal thoughts of death, non-suicidal SDV, and suicidal ideation:
  - Non suicidal thoughts of death
  - Non-suicidal SDV
  - Suicidal ideation

"You said that you have had suicidal thoughts. Would you tell me specifically what you've been thinking when you think of suicide?"

Rudd (2006a)

Multiple Attempters: Risk Assessment

- Increased vulnerability
- Lower threshold of activation of suicidality
- Always deemed to be at *chronic risk*
- Overall risk level: Always at least *"moderate"* acute/overall risk

Rudd (2006a); Rudd et al. (1996)

Acute Suicide Risk Continuum

Mild	**Suicidal ideation of limited frequency, intensity, duration, and specificity. Morbid ideations may be present. There are no identifiable plans; no associated intent; mild dysphoria and related symptoms; good self-control; few other risk factors; and the presence of identifiable protective factors, including social support.**
Moderate	**Frequent suicidal ideation with limited intensity and duration, some specificity in terms of plans; no intent; good self-control; limited dysphoria and other symptoms; some risk and protective factors, including social support.**
High	**Frequent, intense, and enduring suicidal ideation; specific plans; some objective markers of intent (e.g., lethal and available method choices, some preparatory behavior); subjective intent may or may not be present; some impairment in self-control; severe dysphoria and/or other symptoms; multiple risk factors present and few protective factors, particularly social support.**

Rudd (per discussion with CDP; 2013)

Case Study: Assessing Suicide Risk

Treatments for Depression

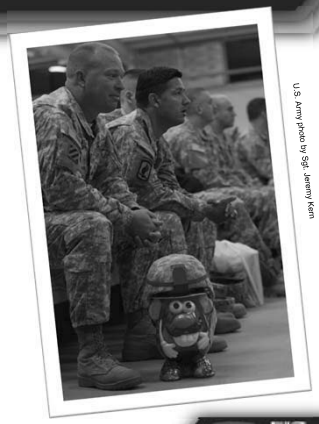
MDD Psychotherapies

<u>Efficacious and Specific</u>

- Cognitive Behavior Therapy (CBT)
- Behavior Therapy
- Interpersonal Psychotherapy (IPT)

<u>Possibly Efficacious</u>

- Brief Dynamic Therapy
- Emotion-Focused Therapy



U.S. Army photo by Sgt. Jeramy Kern

Hollon & Ponniah (2010). VA/DoD Clinical Practice Guideline - Management of MDD (2009)

CBT for Depression: Data from a Meta-Analysis

- Studied in over 75 clinical trials since 1977
- Superior in comparison to waiting list or placebo controls
- No difference in comparison to Behavior Therapy
- Modestly superior in comparison to other therapies
- Significantly better than anti-depressant medication
- Associated with a “preventative” effect

Butler et al. (2006); Gloaguen et al. (1998); Wampold, et al. (2002)

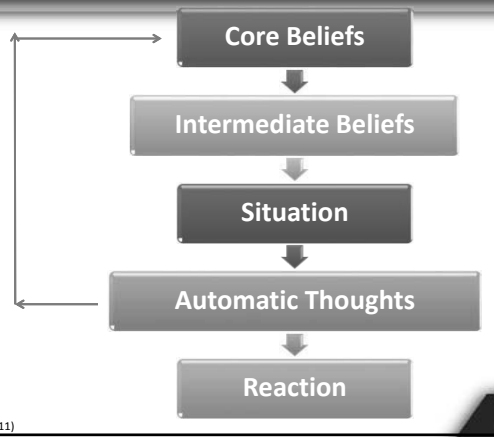
Cognitive Model: Example

Situation
A member of the National Guard finds out that he did not get an expected military promotion.

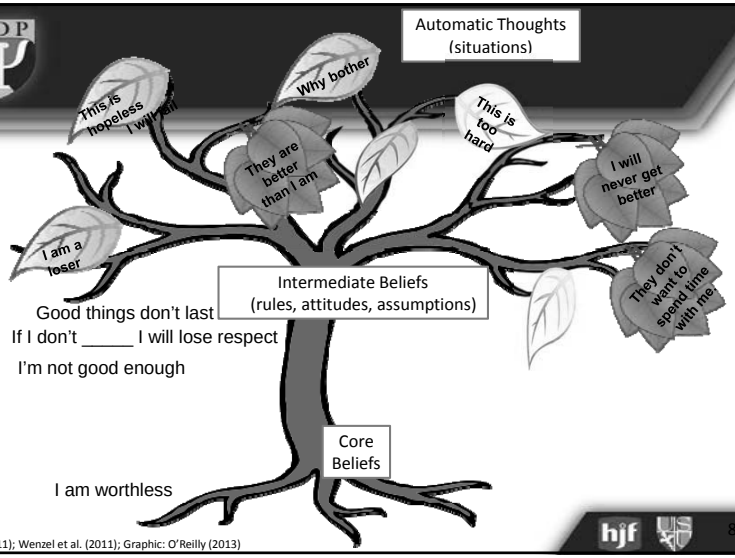
Automatic Thoughts & Images
I'll never amount to anything.

Reaction
Emotional: Depressed mood
Physiological: Feels weighed down
Behavioral: Decreased concentration at work

Expanded Cognitive Model



Beck (2011); Wenzel et al. (2011)



Beck (2011); Wenzel et al. (2011); Graphic: O'Reilly (2013)

Common Cognitive Distortions of Military Personnel

"The Army doesn't care about me"

"I can't trust anyone"

"I should have saved his life"

"Civilians don't care about my sacrifice"

"What I did was unforgiveable"

"If I was driving, my CO would have lived"

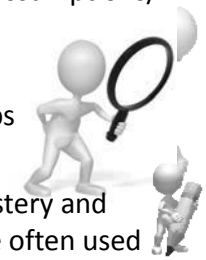
"We shouldn't be fighting over there"

"I'm a coward"

Cognitive Therapy

Treatment Approach

- Identify, evaluate, and modify underlying assumptions/ dysfunctional beliefs
- Learn adaptive coping skills
- Break down large problems in smaller steps
- Decision-making via cost-benefit analysis
- Activity scheduling, self-monitoring of mastery and pleasure, and graded task assignments are often used early in therapy



Beck et al (1979); Butler & Beck (1995)

Behavioral Experiments

Behavioral experiments can modify a patient's negative beliefs more powerfully than verbal techniques.

- Designed collaboratively
- Occur during therapy & between sessions
- Goal = an experience that disconfirms the validity of a cognition

Beck (2011)

General Session Structure

- Mood check
- Bridge from previous session
- Agenda setting
- Review of homework
- Discussion of agenda items
- Periodic summaries
- Homework assignment
- Final summary & feedback

created by Dave Sattler for the MFRI program

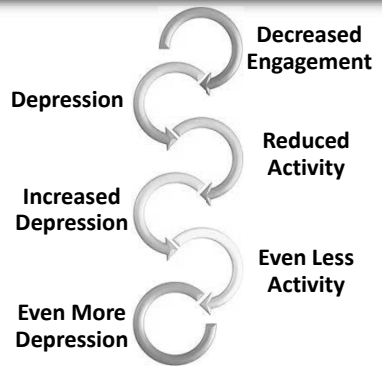
Wenzel et al. (2011); Photo: Military Family Research Institute, Purdue University

Behavioral Theory of Depression

- Behavioral patterns associated with depression:
  - Low rate of response-contingent positive reinforcement
  - High rate of punishment
- Central tenet: Depressed individuals do not get enough positive reinforcement from their interactions with the environment to maintain adaptive behavior

Lewinsohn et al. (1980); Wenzel et al. (2011)

Behavioral Theory of Depression: A Vicious Cycle



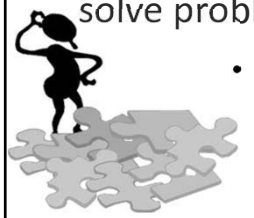
Adapted from Lewinsohn et al. (1986)

Behavior Therapy: Behavioral Activation

- Increase pleasurable and mastery activities
- Increase social activities
- Training in social skills, assertiveness, and problem-solving
- Relaxation training and visual imagery
- Behavioral rehearsal and role playing
- Military considerations
  - Exercise may have at one time been pleasurable, but now may be seen as a mastery activity due to mandatory PT/fitness tests
  - May have decreased activity level due to avoidance related to PTSD

Behavior Therapy: Problem-Solving Therapy

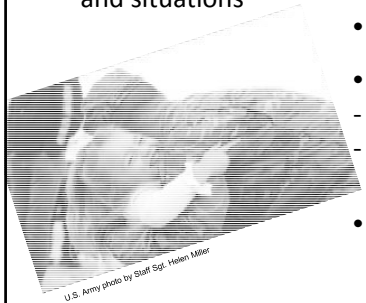
- Therapist and client collaboratively identify and prioritize problems, break problems down into manageable tasks, solve problems, and identify coping skills
  - Discrete, time-limited, structured intervention



Nezu, Nezu, & Perri (1989)

Interpersonal Psychotherapy (IPT)

- **Goal:** To change behavior by fostering adaptation to current interpersonal roles and situations



- Roots in psychodynamic therapy
- But also draws upon
  - Attachment Theory
  - Increased focus on interpersonal relationship
- More structured than dynamic therapy, but less structured than CBT or BT

Klerman et al (1984)

Treatments for Suicidal Ideation and Behavior

VA/DoD Clinical Practice Guidelines

- Suicide-focused psychotherapy to address suicide risk
  - Clinical Practice Guideline Recommendations:
    - Cognitive Therapy is recommended for non-psychotic patients who survived a recent attempt
    - Problem-solving therapy is recommended for nonpsychotic patients with more than one attempt
- Early evidence-based interventions to target specific symptoms
- Follow-up and monitoring

Department of Veterans Affairs/Department of Defense (2013)

Empirically Supported Treatments/ Interventions

- Dialectical Behavior Therapy (DBT)

  Linehan (1993)
- Means Restriction (Public Health Approach)
  - Hawton (2002), Beuatrais (2007), Wiedenmann & Weyerer (1993),
  - Mott et al (2002), Ohberg et al (1995), Law et al (2009)
- Cognitive Therapy for Suicide
  - Brown et al (2005)

Dialectical Behavior Therapy (DBT)

- Goals of DBT according to Linehan:
  - Increase client's behavioral capabilities
  - Improve motivation for skillful behavior through contingency management and reduction of interfering emotions and cognitions
  - Assure generalization of gains to client's environment
  - Structure the treatment environment to reinforce functional rather than dysfunctional behaviors
  - Enhance therapist capabilities and motivation to treat clients effectively

Linehan (1993)

Means Restriction

- Toxic substances
- Medications
- Firearms

Promising Means Restriction Intervention

- **Means Restriction**
  - Actual process of limiting/removing access to lethal means
- **Means Restriction Counseling**
  - Educate patients and supportive others about risk associated with easy availability of means
  - Collaboratively work with patients and support person to limit/remove access to means until the suicidal risk has lessened

Rudd & Bryan (2011); Bryan et al. (2011)

Means Restriction

Possible mechanisms of effectiveness:

1. Limiting access
2. Reducing opportunity for habituation to fear associated with means for suicide

Cognitive Therapy for Suicide

Brown et al (2005)

Results of CT Study

- Significantly fewer suicide attempts in the CT group
- Significantly lower rates of depression in the CT group at 6, 12, and 18 month follow-up
- Significantly lower hopelessness in the CT group at the 6 month point but hopelessness improved overall
- Suicidal ideation went down across the follow-up period but no significant differences between the groups

Brown et al (2005)

Session #: 1 2 3 4 5 6 7 8 9 10
Early Sessions

- Informed consent
- Treatment engagement
- Assessing level of risk
- Developing a safety plan
- Instilling hope
- Developing a cognitive case conceptualization
- Treatment planning

Wenzel et al (2009)

Safety Plan vs Safety Contract?

Wenzel, et al. (2009)

Session #: 1 2 3 4 5 6 7 8 9 10
Middle Sessions

- Modify negative suicide-relevant automatic thoughts & core beliefs
- Teach problem-solving skills
- Help patients develop healthy behavioral coping skills
- Affective coping strategies

Wenzel et al (2009)

Session #: 1 2 3 4 5 6 7 8 9 10
Middle Sessions

- Identify reasons for living
  - Review advantages and disadvantages of living
- Construct survival kit or hope box
  - Memory aid at time of crisis
    - Photographs
    - Letters
    - Safety plan

Wenzel et al (2009)

Session #: 1 2 3 4 5 6 7 8 9 10
Middle Sessions

- Build additional coping skills
  - Exercise regimen, hobbies
- Address impulsivity – "procrastinate" suicide
  - Delay tactics
- Increase adaptive sse of social support
- Improve compliance w/ adjunctive medical & psychiatric services

Wenzel et al (2009)

Session #: 1 2 3 4 5 6 7 8 9 10
Later Sessions

- Relapse prevention task
  - Two guided imagery exercises involving past suicidal crisis
  - One guided imagery exercise involving future suicidal crisis
- Debriefing and follow-up
- Additional treatment planning
  - Continuation of treatment
  - Appropriate referrals
  - Termination

Wenzel et al (2009)

Promising Treatments/ Interventions

- Collaborative Assessment and Management of Suicidality
  - Jobes (2006)
- SAFE Vet
  - Knox et al (2012)
- Means Restriction Counseling
  - Bryan et al (2011)

Means Restriction Counseling

1. Describe the rationale for means restriction
2. Conduct means restriction counseling
3. Implement the result of Step 2

Rudd & Bryan(2011)

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.

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Assessment and Treatment of Depression and Suicidal Behavior Associated with Military Service: An Overview

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PHQ-9 — Nine Symptom Checklist

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

PHQ-9 — Scoring Tally Sheet

Patient Name _____ **Date** _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

How to Score PHQ-9

Scoring Method For Diagnosis

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Scoring Method For Planning And Monitoring Treatment

Question One

- To score the first question, tally each response by the number value of each response:

  Not at all = 0

  Several days = 1

  More than half the days = 2

  Nearly every day = 3
- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

Score	Action
≤4	The score suggests the patient may not need depression treatment.
> 5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

Question Two

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

AMERICAN ASSOCIATION OF SUICIDOLOGY

Risk Factors for Suicide and Suicidal Behaviors I.

Chronic Risk Factors (If present, these increase risk over one's lifetime.)

A. Perpetuating Risk Factors – permanent and non-modifiable

- Demographics: White, American Indian, Male, Older Age (review current rates[1]), Separation or Divorce, Early Widowhood
- History of Suicide Attempts – especially if repeated
- Prior Suicide Ideation
- History of Self-Harm Behavior
- History of Suicide or Suicidal Behavior in Family
- Parental History of:
  - Violence
  - Substance Abuse (Drugs or Alcohol)
  - Hospitalization for Major Psychiatric Disorder
  - Divorce
- History of Trauma or Abuse (Physical or Sexual)
- History of Psychiatric Hospitalization
- History of Frequent Mobility
- History of Violent Behaviors
- History of Impulsive/Reckless Behaviors

Predisposing and Potentially Modifiable Risk Factors

- Major Axis I Psychiatric Disorder, especially:
  - Mood Disorder
  - Anxiety Disorder
  - Schizophrenia
  - Substance Use Disorder (Alcohol Abuse or Drug Abuse/Dependence)
  - Eating Disorders
  - Body Dysmorphic Disorder
  - Conduct Disorder
- Axis II Personality Disorder, especially Cluster B

[1] Available from http://webapp.cdc.gov/sasweb/ncipc/mortrate.html

- Axis III Medial Disorder, especially if involves functional impairment and/or chronic pain)
- Traumatic Brain Injury
- Co-morbidity of Axis I Disorders (especially depression and alcohol misuse), of Axis I and Axis II (especially if Axis II Disorder is Antisocial PD or Borderline PD), of Axis I and Axis III Disorders
- Low Self-esteem/High Self-hate
- Tolerant/Accepting Attitude Toward Suicide
- Exposure to Another's Death by Suicide
- Lack of Self or Familial Acceptance of Sexual Orientation
- Smoking
- Perfectionism (especially in context of depression)

Risk Factors for Suicide and Suicidal Behaviors II

Contributory Risk Factors

- Firearm Ownership or Easy Accessibility
- Acute or Enduring Unemployment
- Stress (job, marriage, school, relationship…)

Acute Risk Factors (If present, these increase risk in the near-term)

- Demographics: Recently Divorced or Separated with Feelings of Victimization or Rage
- Suicide Ideation (threatened, communicated, planned, or prepared for)
- Current Self-harm Behavior
- Recent Suicide Attempt
- Exessive or Increased Use of Substances (alcohol or drugs)
- Psychological Pain (acute distress in response to loss, defeat, rejection, etc.)
- Recent Discharge from Psychiatric Hospitalization
- Anger, Rage, Seeking Revenge
- Aggressive Behavior
- Withdrawal from Usual Activites, Supports, Interests, School or Work; Isolation (e.g. lives alone)
- Anhedonia
- Anxiety, Panic
- Agitation
    - Insomnia
    - Persistent Nightmares

- Suspiciousness, Paranoia (ideas of persecution or reference)
- Severe Feelings of Confusion or Disorganization
- Command Hallucinations Urging Suicide
- Intense Affect States (e.g. desperation, intolerable aloneness, self-hate…)
- Dramatic Mood Changes
- Hoplessness, Poor Problem-solving, Cognitive Constriction (thinking in black and white terms, not able to see gray areas, alternatives…), Rumination, Few Reasons for Living, Inability to Imagine Possibly Positive Future Events
- Perceived Burdensomeness
- Recent Diagnosis of Terminal Condition
- Feeling Trapped, Like There is No Way Out (other than death); Poor Problem-Solving
- Sense of Purposelessness or Loss of Meaning; No Reasons for Living
- Negative or Mixed Attitude Toward Help-Receiving
- Negative or Mixed Attitude by Potential Caregiver to Individual
- Recklessness or Exessive Risk-Taking Behavior, Especially if Out of Character or Seemingly Without Thinking of Consequences, Tendency Toward Impuslivity

Precititating or Triggering Stimuli (Heighten Period of Risk if Vulnerable to Suicide)

- Any Real or Anticipated Event Causing or Threatening:
    - Shame, Guilt, Despair, Humiliation, Unacceptable Loss of Face or Status
    - Legal Problems (loss of freedom), Financial Problems, Feelings of Rejection/Abandonment
- Recent Exposure to Another's Suicide (of friend or acquaintance, of celebrity through media…)

American Association of Suicidology

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

American Association of Suicidology
5221 Wisconsin Ave., N.W.
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www.suicidology.org
info@suicidology.org

If you or someone you know is suicidal, please contact a mental health professional or call 1-800-273-TALK (8255).

Self-Directed Violence Classification System*

Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	N/A	•Non-Suicidal Self-Directed Violence Ideation
	Suicidal Ideation	Thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.	•Suicidal Intent: -Without -Undetermined -With	•Suicidal Ideation, Without Suicidal Intent •Suicidal Ideation, With Undetermined Suicidal Intent •Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.	•Suicidal Intent: -Without -Undetermined -With	•Non-Suicidal Self-Directed Violence, Preparatory •Undetermined Self-Directed Violence, Preparatory •Suicidal Self-Directed Violence, Preparatory
	Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	•Injury: -Without -With -Fatal •Interrupted by Self or Other	•Non-Suicidal Self-Directed Violence, Without Injury •Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, With Injury •Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, Fatal
	Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); **OR** the person is reluctant to admit positively to the intent to die for other or unknown reasons.	•Injury: -Without -With -Fatal •Interrupted by Self or Other	•Undetermined Self-Directed Violence, Without Injury •Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, With Injury •Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, Fatal
	Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with the wish to die cutting her wrists with a knife would be classified as Suicide Attempt, With Injury.	•Injury: -Without -With -Fatal •Interrupted by Self or Other	•Suicide Attempt, Without Injury •Suicide Attempt, Without Injury, Interrupted by Self or Other •Suicide Attempt, With Injury •Suicide Attempt, With Injury, Interrupted by Self or Other •Suicide

* Developed in collaboration with the Centers for Disease Control and Prevention

Self-Directed Violence Classification System*

Key Terms	***Self-Directed Violence:*** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. ***Suicidal Intent:*** There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior. ***Physical Injury:*** A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological injury is excluded in this context. ***Interrupted By Self or Other:*** A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point. ***Suicide Attempt:*** A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior. ***Suicide:*** Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

* Developed in collaboration with the Centers for Disease Control and Prevention

How do you Remember the Warning Signs of Suicide?

Here's an Easy-to-Remember Mnemonic:

IS PATH WARM?

I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Change

A person in acute risk for suicidal behavior most often will show:

Warning Signs of Acute Risk:

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

These might be remembered as expressed or communicated **IDEATION**. If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Additional Warning Signs:

- Increased **SUBSTANCE** (alcohol or drug) use
- No reason for living; no sense of **PURPOSE** in life
- **ANXIETY**, agitation, unable to sleep or sleeping all the time
- Feeling **TRAPPED** - like there's no way out
- **HOPELESSNESS**
- **WITHDRAWING** from friends, family and society
- Rage, uncontrolled **ANGER**, seeking revenge
- Acting **RECKLESS** or engaging in risky activities, seemingly without thinking
- Dramatic **MOOD** changes

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

These warning signs were compiled by a task force of expert clinical-researchers and 'translated' for the general public.

American Association of Suicidology (2012); retrieved from: http://www.suicidology.org

SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

VA Safety Plan: Brief Instructions*

Step 1: Recognizing Warning Signs

__ Ask "*How will you know when the safety plan should be used?"*

__ Ask, "*What do you experience when you start to think about suicide or feel extremely distressed?*"

__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

__ Ask *"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"*

__ Ask *"How likely do you think you would be able to do this step during a time of crisis?"*

__ If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"

__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.

__ Ask *"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"*

__ Ask patients to list several people and social settings, in case the first option is unavailable.

__ Ask for safe places they can go to do be around people, e.g. coffee shop.

__ Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.

__ Ask *"Among your family or friends, who do you think you could contact for help during a crisis?"* or *"Who is supportive of you and who do you feel that you can talk with when you're under stress?"*

__ Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.

__ Ask *"How likely would you be willing to contact these individuals*?"

__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.

__ Ask *"Who are the mental health professionals that we should identify to be on your safety plan?"* and *"Are there other health care providers?"*

__ List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255))

__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.

__ For methods with low lethality, clinicians may ask veterans to remove or restrict their access to these methods themselves.

__ Restricting the veterans' access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

*See Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008) for a full description of the instructions.

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

The Unique Challenges of Military Families

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.

Learning Objectives

1. Discuss factors that impact marriage, divorce, and relationships in military families.
2. Recognize stressors and risk factors for military families throughout the stages of the deployment cycle.
3. Recognize mechanisms of resilience and protective factors for military families throughout the stages of the deployment cycle.
4. Identify relevant themes for therapy with military families through the stages of the deployment cycle.

Agenda

- The Definition of the Military Family
- Military Marriages
- Military Family Life
- The Impact of the Deployment Cycle on Military Families
- Resources

The Definition of the Military Family

"When one person joins the military the whole family serves."

Family Demographics

Total Force Military Personnel & Family Members

2013 Demographics Profile of the Military Community (2014)

Military Families

- **Dependents**
  - **Spouses ****
  - **Children**
  - **Stepchildren**
- Non-Dependents
  - Parents *
  - Siblings *
  - Extended family
  - Unmarried partners
  - Adult children

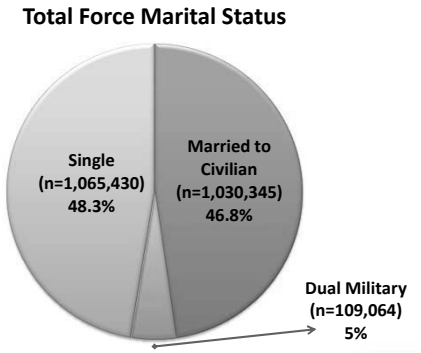
U.S. Marine Corps photo by LCPL Jacob Barber

U.S. Army photo by SSG Ben Navratil/Released

Military Marriages

"If the Army wanted you to have a wife, they would have issued you one."

Marital Status



2013 Demographics Profile of the Military Community (2014)

Military Marriages

Unique attributes of military marriages:

- When the military calls, the Service member must go
- Separation is standard
- Reunification is also a normal occurrence
- Separation from family/friends is common

Devries et al. (2012)

Marriage and Divorce in the Military

Photo by AzureCitizen. Image courtesy of: http://en.wikipedia.org/wiki/GNU_Free_Documentation_License

- Young marriages
- Marriage/divorce rates
- Impact of deployment
- Marital quality
- Infidelity

Adler-Baeder et al. (2005) Hogan & Seifert (2010); Karney & Crown (2007); Karney et al. (2012); Negrusa et al. (2014); Riviere et al. (2012); Schumm et al. (2012); Snyder et al. (2012)

Increased Hazard of Divorce

- Greater cumulative time deployed
- Couples married before 9/11
- Effect of deployment greater for:
  - Female Service members
  - Service members in dual-military marriages

Negrusa et al. (2014)

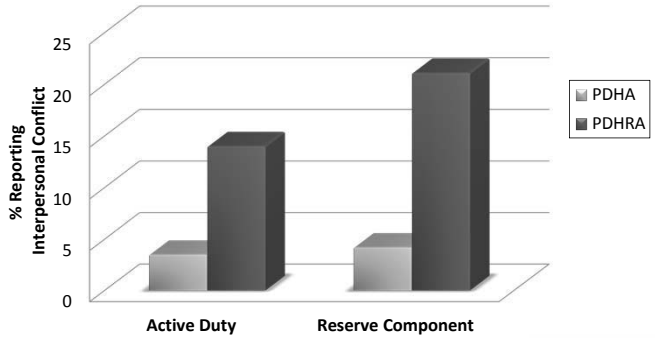
Marital Quality

Examined 2003-2009 trends in marital functioning indicators:

- Marital quality declined
- Reports of past-year infidelity increased
- Reports of separation/divorce intent increased
- *No increases observed* in marital dissolution rates

Riviere et al. (2012)

Impact of Deployment on Couples



Milliliken et al. (2007)

Evidence-Based Couples Counseling in the DoD/VA

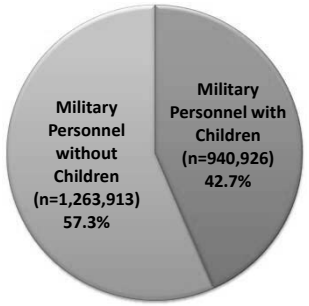
- Gottman Method Couples Therapy
  - http://www.gottman.com
- Emotionally Focused Therapy for Couples (EFT)
  - http://www.iceeft.com
- Integrative Behavioral Couples Therapy (IBCT)
  - http://ibct.psych.ucla.edu
- Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT) *
  - http://www.coupletherapyforptsd.com

Military Families

"Military families are families with unique challenges."

Parental Status

Total Force Parental Status



2013 Demographics Profile of the Military Community (2014)

"Greedy Institutions"

Both the military and families demand:

- Commitment
- Loyalty
- Time
- Energy

Blaisure et al. (2012); Segal (1986)

Family Stressors

Normative	• Occur for most families • Expected
Normative Military	• Occur for most **military** families • Expected
Catastrophic	• Do not occur to most families • Unexpected

Blaisure et al. (2012)

Normative Stressors of Military Family Life

- Frequent relocations (PCS)
- Spouse employment opportunities
- Separations
- Deployments
- Risk of injury or death

Image courtesy of: http://www.dodlive.mil/index.php/2011/06/how-to-ease-the-summertime-move/

Blaisure et al. (2012); Lim & Schulker (2010)

If you knew you had to move your entire household every 2-3 years, how would you live your life differently than you do now?

Blaisure et al. (2012), p. 57

2014 Blue Star Families Survey

<u>Top Stressors Associated with the Military</u>

- 69% = Deployments
- 51% = Isolation from family & friends

<u>Military Spouse Employment</u>

- 84% (employed) = military lifestyle negatively impacted pursuit of career
- 53% (unemployed) = would like to be employed outside the home

Blue Star Families (2014)

Normative Military Stressors for Children

- Relocation
- Education
- Child Care
- Deployments

Blaisure et al. (2012)

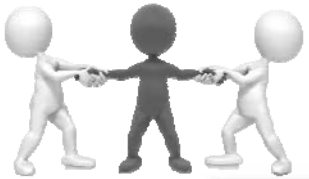
Resiliency in Military Children

- Sense of belonging/community
- Adaptable
- Tolerant of diversity
- Responsible/independent
- Respect for authority

Easterbrooks et al. (2013); Hall (2012); Park (2011)

Blended Families

- Children of different developmental ages and stages
- Higher risk of emotional / behavioral problems
- Torn between biological parents
- Two households
- Issues of isolation



Adler-Baeder et al. (2005); Hall (2008)

LGB Families

- 20 September 2011 = Repeal of DADT
- 26 June 2013 = Repeal of Section 3 of DOMA

U.S. Army photo by SFC Stanley Matuszak/Released

- Prejudice/ Discrimination
- Identity Concealment
- Relocation Issues
- Social Support

Ender et al. (2012); Herek (2009); Oswald & Sternberg (2014)

Keys to Family Resilience

Family Belief Systems	Family Organizational Patterns	Family Communication Processes
Making meaning of adversity	Flexibility	Clarity
Positive outlook	Connectedness	Open emotional expression
Transcendence & spirituality	Social & economic resources	Collaborative problem solving

Walsh (2006)

Mechanisms of Resilience in Military Families

- Psychoeducation & developmental guidance
- Shared family narratives
- Open & effective communication
- Family resiliency (coping) skills
- Effective & coordinated parent leadership

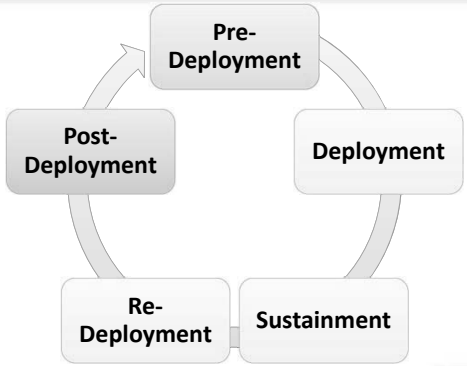
Saltzman et al. (2014)

Resiliency Training for Military Families

- FOCUS (Families OverComing Under Stress)
  - http://www.focusproject.org
  - http://www.focusworld.org
- HomeFront Strong
  - http://m-span.org/programs-for-military-families/homefront-strong

The Deployment Cycle & Its Impact on Family Members

Emotional Cycle of Deployment



Pincus et al. (2001)

MilSpouse Cycle of Deployment

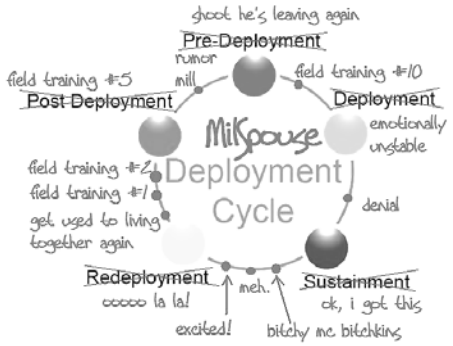


Image courtesy of: Patricia Santiago (2010)

Case Study: Alison Talks about Deployments

Parenting Cycle of Deployment

Pre-Deployment	Deployment	Post-Deployment
Looking Ahead	Parenting (War Zone / Home Front)	Facing Reality
Saying Goodbye	Surviving the Home Stretch	Moving Forward

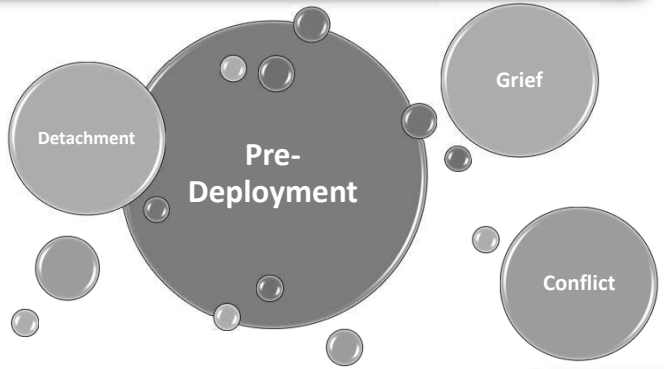
DeVoe & Ross (2012)

Pre-Deployment Stage

"A holding pattern during which life cannot yet begin."

DeVoe & Ross (2012)

Emotional Reactions



DeVoe & Ross (2012)

Parenting

- Looking Ahead
  - How/when to communicate with children about impending departure
  - Handling feelings & responding to children
- Saying Goodbye
  - Importance of saying goodbye face-to-face

Pre-Deployment

DeVoe & Ross (2012)

Helping Families

- Facilitate communication
  - Sharing of feelings
  - Discussion of expectations
- Foster connection
- Teach positive coping skills
- Emphasize the importance of support
- Help couples address practical issues
- Discuss parenting issues

Pre-Deployment

Pavlicin (2003); Pincus et al. (2001)

Helping Children

- Encourage quality time with each child
- Emphasize honesty
- Help parents provide reassurance
- Foster connection
- Create communication plan
- Facilitate conversations with schools/teachers

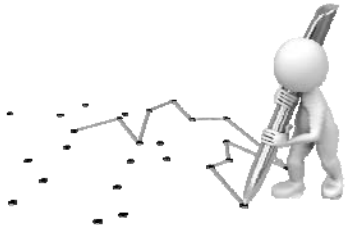
DoD photo by PO2 Stephanie Tigner/Released

Pre-Deployment

Military OneSource (2013); Pavlicin (2003)

Themes for Therapy

- Affective Education
- Exploring Roles
- Exploring Unresolved Conflicts
- Expectations of Fidelity



Pre-Deployment

Laser & Stephens (2012)

Deployment Stage

"Repeat after me … I can do this."

Emotional Reactions

- <u>Deployment</u>
  - Disorientation, mixed emotions
  - Relief that anticipation is over
- <u>Sustainment</u>
  - Self-growth, independence
  - Less angry, but lonelier
- <u>Re-Deployment</u> (*Anticipation of Return*)
  - Excitement, apprehension

Deployment

DeVoe & Ross (2012); Pincus et al. (2001)

Parenting

- Parenting from the Home Front
  - Increased responsibilities = increased stress
- Parenting from a War Zone
  - Relinquishment of daily involvement
  - Adaptation of new strategies
- Surviving the Home Stretch
  - How will children respond to reunion?

Deployment

DeVoe & Ross (2012)

Deployment Protective Factors

- Family readiness
- Active coping styles
- "Making meaning" of the deployment
- Strong community of social support
- Acceptance of military lifestyle
- Optimism
- Self-reliance
- Ability to adopt flexible gender roles

Hammer et al. (2006); Patterson & McCubbin (1984); Rosen et al. (1993); Walsh (2006); Weins & Boss (2006)

Family Risk Factors During Deployment

- Rigid coping style
- History of family dysfunction/ behavioral health problems
- Families experiencing first military separation
- New to duty location
- Young families
- Pregnant spouses
- Single parent families
- Dual military families
- Families with foreign spouses
- Blended families
- Selected Reserve

Blount et al. (1992); Darwin (2012); Hall (2008) Huffman & Payne (2006); Kelley (2006); Weins & Boss (2006); Wolpert et al. (2000)

Impact of Deployment on Children

- Emotional / Behavioral Difficulties
- Cumulative Months of Deployment
- Child Maltreatment

US Army photo by PFC Jessica M. Kuhn. Image courtesy of: https://creativecommons.org/licenses/by/2.0/legalcode

Deployment

Chandra et al. (2011); Flake et al. (2009); Gibbs et al. (2007); Lester et al. (2010); Rentz et al. (2007)

Parental Deployment & Adolescent Mental Health

Reporting of any familial deployment (parent or sibling) was associated with increased odds of experiencing:

- Sadness/hopelessness
- Depressive symptoms
- Suicidal ideation

Cederbaum et al. (2013)

2014 Blue Star Families Survey

Top 5 **Positive** Impacts of Deployment on Children

- Adaptability
- Increased Independence
- Personal Growth
- Increased Resilience
- Increased Pride

Top 5 **Negative** Impacts of Deployment on Children

- Separation Anxiety
- Worry
- Irritability
- Difficulty Sleeping
- Difficulty Concentrating

Blue Star Families (2014)

Case Study: Kayla Talks about Deployments

Helping Families

- Facilitate setting personal goals
- Encourage creation of a support network
- Teach stress management techniques
- Highlight the importance of self-care

Deployment

Pavlicin (2003)

Helping Children

- Encourage consistency & routine
- Highlight the importance of support from other adults
- Help parents model self-care
- Facilitate good communication
- Emphasize the importance of fun
- Remind parents to let kids be kids

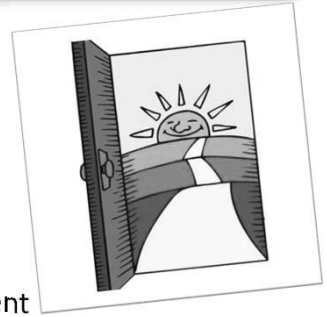
Deployment

Hall (2008); Pavlicin (2003)

Case Study: Kayla's Experience During Deployment

Themes for Therapy

- Deployment: Stress Reduction
- Sustainment: Resilience & Growth
- Re-Deployment: Expectation Management



Deployment

Laser & Stephens (2012)

Post-Deployment Stage

"Hello, Stranger.
Let's cohabit and raise these kids."

Sanderlin (2012)

Emotional Reactions

Reunion	Reintegration
• Elation • Relief • Frustration	• Tension • Resentment • Comfort

Post- Deployment

Logan (1987); Pincus, et al. (2001)

Case Study: Homecoming

Parenting

- Facing Reality
  - Reconnect & rebuild parent-child relationships
  - Role negotiation / co-parenting challenges
- Moving Forward
  - Re-establish family equilibrium
  - Develop new parenting routines
  - Incorporate legacy of deployment

Post- Deployment

DeVoe & Ross (2012)

The Impact of Mental Health Issues

- Depression, PTSD
- Caregiver Burden
- "As goes the parent, so goes the child"

Blaisure et al. (2012); Blow et al. (2013); Flake et al. (2009); Goff et al. (2007); Lester et al. (2010); Saltzman, et al. (2014); Sayers et al. (2009); Tanielian et al. (2013)

Case Study: Alison Talks about James' Return Home

Case Study: Kayla Talks about Her Dad's Return Home

Facilitating Successful Reunions

Service Member's Expectations	Partner's Expectations	Therapist's Role (how to help)
Isolate vs. great sex 24/7	Fairy-tale reunion	**Set realistic expectations**
Immediate return to "old ways"	New routines	**Remind that adjustment takes time**
Separated from family	Earned a break	**Stress that both made sacrifices**
No one understands	Drill with questions	**Teach communication skills**

Military OneSource (2012); Pavlicin (2003)

Successful Reunions with Children

Things to remember:

- Children react differently to homecoming depending on their age & relationship with deployed parent
- Children are often loyal to the parent that stays behind
- Children may feel anxious about the Service member leaving again
- Children will wonder if rules at home will change

Post- Deployment

Pavlicin (2003); Pincus et al. (2001)

Child Development and Reunion & Reintegration

Children respond differently to homecomings and parental reintegration depending on their age and developmental stage.

Post- Deployment

Themes for Therapy

- Revisiting Family Roles
- Opening Communication
- Creating Opportunities for Appreciation and Caring

Post- Deployment

Laser & Stephens (2012); Image by: Scott Maxwell, http://thegoldguys.blogspot.com.
Image courtesy of: https://creativecommons.org/licenses/by-sa/2.0/legalcode

Online Resources

Please see **Military Families Online Resources Handout** for additional military family resources.


Military Family Online Resources

Military Family Resources:
Military One Source: http://www.militaryresource.mil
Military Family Research Institute: https://www.mfri.purdue.edu
After Deployment: http://afterdeployment.dcoe.mil
Real Warriors: http://www.realwarriors.net
Yellow Ribbon Program: http://www.yellowribbon.mil
Military Partners & Families Coalition: http://www.mfpfi.org

Military Child Resources:
Military Kids Connect: https://militarykidsconnect.dcoe.mil
Talk, Listen, Connect: http://www.sesamestreet.org/parents/topics/deployedparent
Zero to Three: http://www.zerotothree.org/
Military Child Education Coalition: http://www.militarychild.org/
Military Youth Coping with Separation Video: http://bit.ly/1qAqaEl

Evidence-Based Couples Counseling in the DoD/VA:
Gottman Method Couples Therapy:
http://www.gottman.com
http://oef1.amedd.army.mil

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
Department of Medical & Clinical Psychology
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road, Executive Office: Bldg. 11300-602
Bethesda, MD 20813-4768

Email: General@DeploymentPsych.org
Website: DeploymentPsych.org
Facebook: http://www.facebook.com/DeploymentPsych
Twitter: @DeploymentPsych

Resources

Military OneSource

- Confidential services available via telephone & online
- Comprehensive information on every aspect of military life:
  - Deployment
  - Reunion
  - Relationships
  - Grief
  - Spouse employment & education
  - Parenting & childhood

Military OneSource

http://www.militaryonesource.mil

FOCUS: Families OverComing Under Stress

- Training in core resilience skills
  - Emotion regulation
  - Communication
  - Problem solving
  - Goal-setting
  - Managing deployment reminders
- FOCUS World (online resiliency training)
- FOCUS On the Go! (mobile app)

Image courtesy of: http://www.dodlive.mil/index.php/2010/12/medical-monday-project-focus/

http://www.focusproject.org

FOCUS World

FOCUS World (www.focusworld.org) is an interactive, online educational tool that helps military families become stronger in the face of challenges by providing both parents and kids a fun place to learn and practice important skills, such as:

http://www.focusworld.org

Military Kids Connect

- Online community for military children (ages 6-17)
- Access to age-appropriate resources to support children dealing with the challenges of military life
- Additional resources for parents & teachers

http://www.militarykidsconnect.dcoe.mil

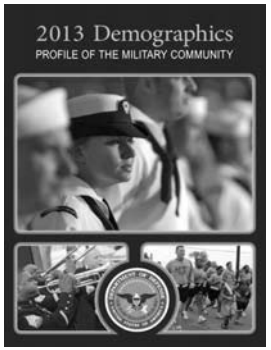
Military Kids Connect

http://www.militarykidsconnect.dcoe.mil

Sesame Street Toolkit: Talk, Listen, Connect

- DVDs: Deployment, Homecomings, Grieving
- Website: Military Families Near & Far
- Mobile Apps:
  - Sesame Street for Military Families
  - The Big Moving Adventure

http://www.sesamestreet.org/parents/topicsandactivities/toolkits/tlc



Department of Defense 2013 Demographics Profile of the Military Community

http://www.militaryonesource.mil
Click on "Reports and Surveys"

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Reunion & Reintegration with Children

Infants/Toddlers *(Ages 0-3)*

Infancy is a time of rapid growth and development (both physically and cognitively). Attachment is the major developmental milestone during this stage.

Homecoming Reactions

- "Stranger Reaction"
- Increased sensitivity
- Crying, clinginess, disrupted schedule
- Delayed milestones
- Temper tantrums
- Nightmares
- Regression in skills

Fostering Reintegration

- Realistic expectations
- Direct contact
- Consistency
- Opportunities for connection
- Take things slowly
- Expect regression

Pre-schoolers *(Ages 3-6)*

During the pre-school stage, growth and development continue at a rapid pace. Children perceive that everything revolves around them and magical thinking predominates.

Homecoming Reactions

- Personalize stress
- Regression in skills
- Acting out
- Time to warm up

Fostering Reintegration

- Ignore regressive behaviors
- Listen & answer questions
- Opportunities for connection
- Take things slowly

School Age Children *(Ages 6-12)*

During the school years physical development slows. Children begin to find their place in the world, and they show increases in organization, responsibility, and cognitive and moral development.

Homecoming Reactions

- Whiny, aggressive, irritable
- Need time to talk
- Need physical attention
- Rapid mood shifts
- Excitement
- Fear

Fostering Reintegration

- Slowly transition roles/ responsibilities
- Include Service member in routines
- One-on-one time
- Connect to school/ community resources

Adolescents *(Ages 12-18)*

Adolescence is the time when children prepare for adulthood. Puberty occurs and there is an increased reliance on the peer group to determine norms. Adolescents are now capable of abstract thinking. It is very common for there to be parent/child tension during this time.

Homecoming Reactions

- Emotionally guarded
- Acting out
- Lower grades
- Relief
- Concern about roles/ responsibilities
- Sensitivity

Fostering Reintegration

- Open communication
- Consistency
- Transition roles/ responsibilities
- One-on-one time
- Respect privacy

Barnett et al. (2012), Derenne (2008); Photos: http://www.morgeufile.com

Military Family Online Resources

Military Family Resources:

Military One Source: http://www.militaryonesource.mil

Military Family Research Institute: https://www.mfri.purdue.edu

After Deployment: http://afterdeployment.dcoe.mil

Real Warriors: http://www.realwarriors.net

Yellow Ribbon Program: http://www.yellowribbon.mil

Military Partners & Families Coalition: http://www.milpfc.org

Military Child Resources:

Military Kids Connect: https://militarykidsconnect.dcoe.mil

Talk, Listen, Connect: http://www.sesamestreet.org/parents/topicsandactivities/toolkits/tlc

Military Families Near & Far: https://www.familiesnearandfar.org

Zero to Three: http://www.zerotothree.org/

Military Child Education Coalition: http://www.militarychild.org/

Military Youth Coping with Separation Video: http://bit.ly/1qAjqIO

Evidence-Based Couples Counseling in the DoD/VA:

Gottman Method Couples Therapy:

http://www.gottman.com

http://csf2.army.mil

Emotionally Focused Therapy for Couples (EFT):

http://iceeft.com

http://www.strongbonds.org

Integrative Behavioral Couples therapy (IBCT): http://www.ibct.psych.ucla.edu

Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT): http://www.couplestherapyforptsd.com

Resiliency Training for Military Families:

Families Overcoming Under Stress (FOCUS): http://www.focusproject.org/

FOCUS World: http://www.focusworld.org

HomeFront Strong: http://m-span.org/programs-for-military-families/homefront-strong/