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.

Therapist Challenges

What are the hardest parts about working with depressed and/or suicidal patients?

What are your negative thoughts about seeing suicidal patients in particular?

Dysfunctional Therapist Cognitions

- **Fortune Telling**
  - "She won't ever get better—she has been depressed too long."
  - "I won't be able to manage my caseload with all the extra work required for my suicidal clients."
- **Should Statements**
  - "People should not consider suicide as an option."
  - "I should feel more optimistic about my client's progress."

Beck (1976); Burns (1980)

Outline

- Military Depression and Suicide Rates
- Etiology of Depression and Suicide
- Depressive Spectrum Disorders: Diagnostic Criteria
- Risk Factors, Warning Signs & Protective Factors
- Assessment of Depression and Suicide
- Treatment of Depression and Suicidal Behavior

Military Depression and Suicide Rates

Depression Among 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)

Depression and Veterans

- Diagnosis rate for depression→14%
  - –Yet studies show that depression is under-diagnosed in the Veteran population
- 11% of veterans aged 65+ years have a diagnosis of MDD (twice the rate of adults 65+ in the general population)

National Alliance on Mental Illness (2009); www.mentalhealth.va.gov

Suicide >

Homicide or War-Related Deaths

Reza et al. (2001)

Every year…

- Almost 1 million people die from suicide
- 16 per 100,000
- 1 every 40 seconds

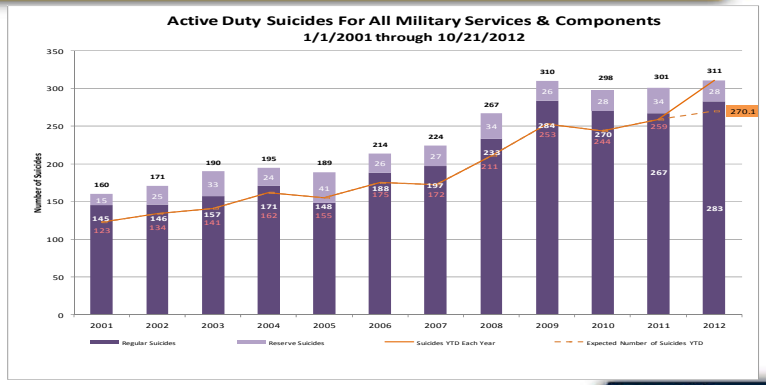
World Health Organization (2013)

National (U.S.) Significance

- 1 suicide every 13.7 minutes
- 12.4 per 100,000
- Steady rise in suicide since 2000

http://www.afsp.org/understanding-suicide/fact-and-figues

DoD Suicide Deaths by Component and Calendar Year



Mortality Surveillance Division, Armed Forces Medical Examiner

DoD Suicide Rates by Service & Component (DoDSER, 2011)

		Air Force	Army	Marine Corps	Navy	General Population (CY 2010)
	Total Count	50	167	32	52	38,364
	Rate/ 100K	13.27	22.90	14.87	14.98	12.43
Component	Regular	42	142	31	52	
	Reserve	3	8	1	0	
	National Guard	5	17	N/A	N/A	

Luxton et al. (2012)

Military Veteran Suicide Rates

- National estimates suggest that about 22% of US suicides each year are veterans
- On average, 22 veterans die by suicide each day
- Male and female veterans had higher firearm suicide rates than nonveterans

Kemp & Bossarte (2013); 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

Warriors See the World Differently

Photo: afterdeployment.org

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.

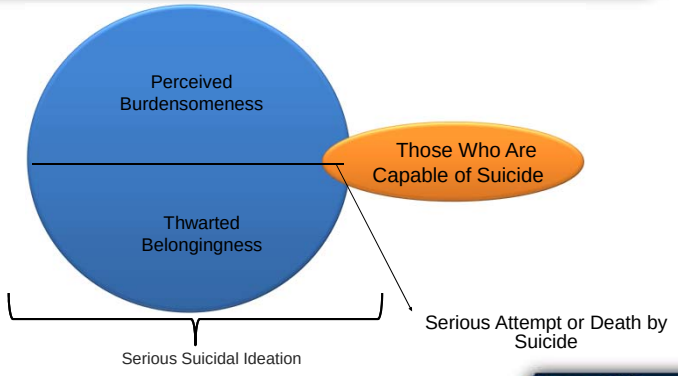
If I seek help …

- 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; Photo: Navy Medicine

Why Do Some People Die by Suicide?

Interpersonal-Psychological Theory of Suicide Risk



Joiner (2005)

2 Most Significant Contributors to Suicidal Ideation

✓Thwarted Belongingness

✓Perceived Ineffectiveness/Burden

Joiner (2005); Image courtesy of S. Miquez.

Thwarted Belongingness

Need:

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

Interactions must be frequent and positive

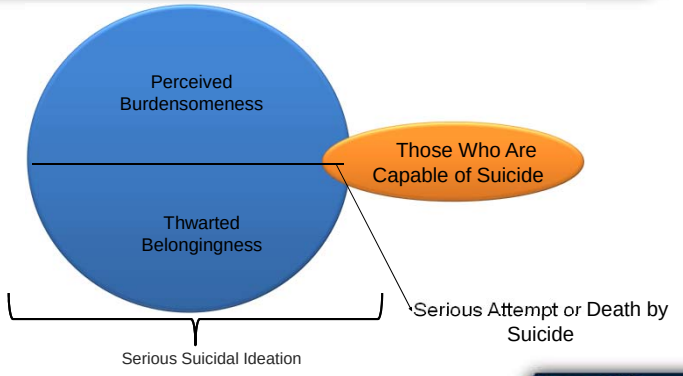
Joiner (2005)

Perceived Ineffectiveness/Burden

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

Joiner (2005)

Interpersonal-Psychological Theory of Suicide Risk



Joiner (2005)

Acquired Ability

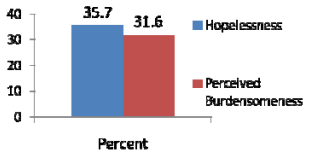
Reduction of fear through repeated self-injury is necessary for serious suicidal behavior to occur (can occur in the short term or over the long term)

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

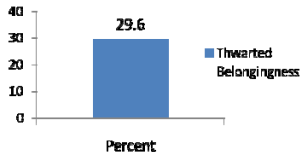
Joiner (2005)

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

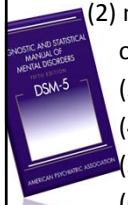
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/ Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder/ Unspecified Depressive Disorder

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.

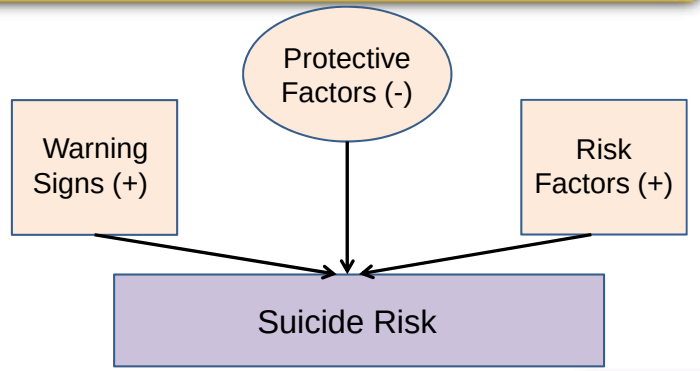
Trauma and Depression

- Trauma reactions do not *only* include PTSD
- There is overlap between PTSD and depression symptoms and co-morbidity rates are high
- Some military personnel join the service with a history of depression and/or trauma history
- Depression may develop during a service member's military career without it being linked to deployment or a traumatic event

Tanielian & Jayacox (2008)

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

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
- 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)

Mental Health Diagnosis 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)

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

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)

Sleep: Active Duty

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

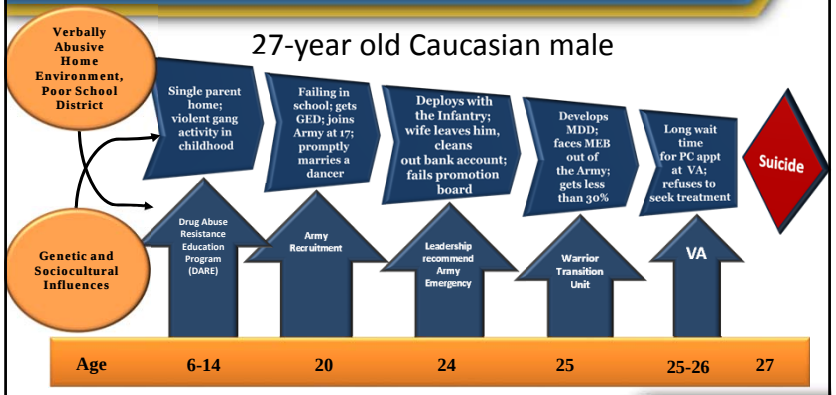
Ribeiro et al. (2012)

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)

Developmental Trajectory



Assessment of Depression and Suicide

What Do Depressed or Suicidal Service Members Look Like?




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)

Diagnostic Interview Overview

- Identify relevant factors on presenting problem
- Gather info on history of problem and other pertinent history
- Conduct mental health screening
- Elicit info regarding risk/protective factors
- Conduct suicide specific inquiry
- Formulate a diagnosis
- Estimate the level of risk
- Make treatment recommendations

Jones et al. (2012)

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)

Assessing Risk
Continued

Other Aspects of Risk to Assess

Identifiable precipitants

Symptomatic presentation

Suicide warning signs

Impulsivity and self-control

Protective factors

Rudd (2006a)

Acute Suicide Risk Continuum

Frequent, intense, and enduring suicidal ideation, specific plans; some objective markers of intent (e.g., lethal and available method choice, some preparatory behaviors); subjective intent may or may not be present; some impairment in self-control; severe dysphoria and/or other symptoms; multiple risk factors present; few protective factors, particularly social support.

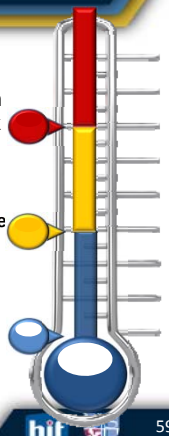
High Risk

Frequent suicidal ideation with limited intensity and duration, some specificity in terms of plans but no intent, good self-control, limited dysphoria and other symptoms. Some risk and protective factors, including social support.

Moderate Risk

Suicidal ideation of limited frequency, intensity, duration, and specificity. Morbid ideations may be present. No identifiable plans; no associated intent. Mild dysphoria and related symptoms, good self-control. Few other risk factors and the presence of protective factors, including social support.

Mild Risk



adapted from Rudd (2006a)

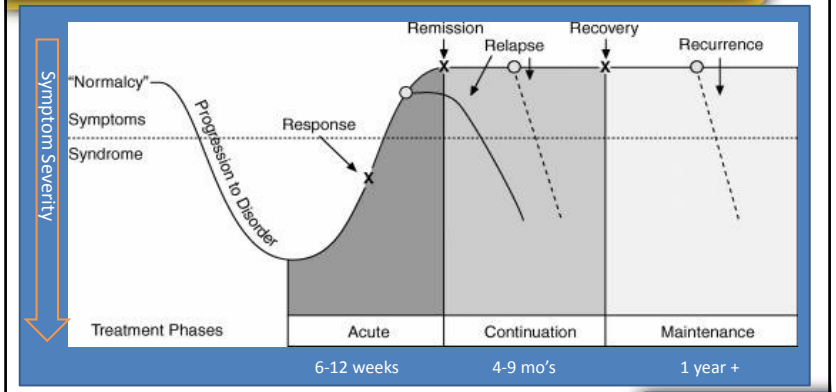
Multiple Attempters and Risk Level

- Remember that a history of two or more suicide attempts reflects the presence of *chronic baseline risk*
- Individuals with chronic baseline risk will always be at least at *moderate* acute/overall risk

Rudd (2006a)

Treatments for Depression

Course/Phases of Depression



Kupfer (1991)

MDD Psychotherapies

Efficacious and Specific

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

Possibly Efficacious

- Brief Dynamic Therapy
- Emotion-Focused Therapy

Hollon & Ponniah (2010)

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)

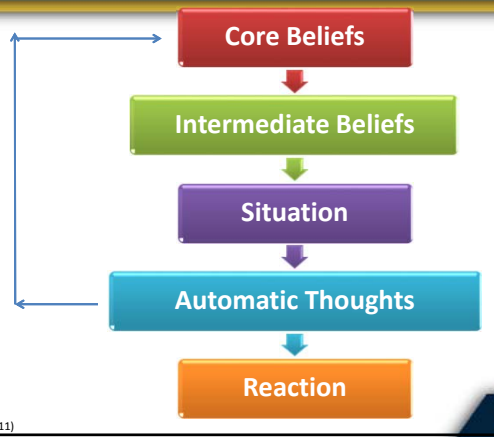
Cognitive Model: Example

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)

Common Cognitive Distortions of Military Personnel

- "The Army doesn't care about me"
- "You 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"

Behavioral Experiments

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

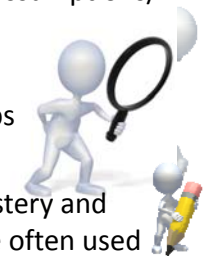
- Designed collaboratively
- Occur during therapy & between sessions
- Goal = an experience that disconfirms the validity of a cognition

Beck (2011)

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)

Cognitive Therapy

Session Structure

1. Brief Mood/ Symptom Check
2. Agenda Setting
3. Bridge from Previous Session
4. Homework Review
5. Discussing Issues on Agenda
6. Setting New Homework
7. Summarizing/ Soliciting Feedback from Patient

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

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)

Cycle of Depression

Adapted from Lewinsohn et al. (1986)

Behavior Therapy: Behavioral Activation

- Help patients understand the environmental sources of their depression
- Target behaviors that might maintain or worsen the depression
- Working assumption: Negative life events can lead to individuals experiencing low levels of positive reinforcement in their lives
- Many of the coping behaviors that people engage in may worsen the problem over time, via negative reinforcement

Jacobson et al (2001); Martell et al (2001)

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)

Therapies Effective in the Prevention of MDD Relapse/ Recurrence

Cognitive Behavioral Therapy (CBT)

Mindfulness-Based Cognitive Therapy

Hollon & Ponniah (2010)

Mindfulness-Based CBT

Core Aim

To prevent depression relapse/ recurrence

Goals

1. Becoming more aware of bodily sensations, feelings and thoughts from moment to moment.
2. Developing mindful acceptance of unwanted feelings and thoughts, rather than habitual, automatic programmed routines.
3. Choosing the most skillful response to any unpleasant thoughts, feelings, or situations.

Segal, Williams, & Teasdale (2013)

Mindfulness-Based CBT

Core Themes

1. Preventing the establishment & consolidation of patterns of negative thinking
2. The 7 signs of driven-doing
3. Core skill: How to exit and stay out of these self-perpetuating cognitive routines
4. Kindness plays an essential role
5. Experiential learning
6. Empowerment
7. Skills to be learned

Treatments for Suicidal Ideation and Behavior

Empirically Supported Treatments/ Interventions

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

Dialectical Behavior Therapy (DBT)

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

Means Restriction

- Toxic substances
- Medication
- Firearms

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?

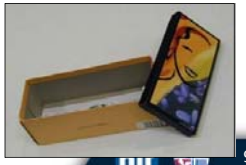
Session #: 1 2 3 4 5 6 7 8 9 10
Middle Sessions

- 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 Use 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

Bryan & Rudd (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.

How to Contact Us

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