



Managing Suicide Risk in Combat Zones

Critical Information for Clinicians & Commanders

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Disclaimer

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Objectives

Attendees will be able to:

1. Recognize challenges in managing suicide risk in deployed settings.
2. Demonstrate understanding of a risk assessment approach.
3. Identify strategies to manage suicide risk in a deployed setting.

Overview

- Background
- Risk Factors and Modifications
- Summary
- Case Example
- Questions/Discussion

Bryan, C.J., Kanzler, K.E., Durham, T.L., West, C.L., & Greene, E. (2010). Challenges and considerations for managing suicide risk in combat zones. *Military Medicine*, 175, 713-718.

Background

- Informal Poll: Raise your hand if you...
 - Deployed
 - Have had any challenges dealing with at-risk service members
 - Ever needed to “think outside the box” to deal with risk issues

Background

- Informal Poll: Raise your hand if you...
 - Deployed
 - Have had any challenges dealing with at-risk service members
 - Ever needed to “think outside the box” to deal with risk issues
- Suicides do happen in war zones
 - 11% of all 2010 military suicides (DoDSER, 2010)
 - Suicide “risk” is far more common
 - Need for modification of standard approaches



Suicidality and Risk Management

DEPLOYMENT-SPECIFIC FACTORS



EVERYONE'S PACKING HEAT

Everyone's Packing Heat

- **Firearms used more for suicides** (DoDSER, 2010)
 - 58% in garrison
 - 96.7% deployed
- **Very high lethality**
- **Suicidal crises are time-limited**
- **Suicides are usually impulsive reactions**
- **Survivors of life-threatening attempts:**
(Simon et al, 2001)
 - 24% decided within 5 minutes
 - 70% within hour

Managing Everyone Packing Heat

Here...

- **Means Restriction**
- Duty weapon removed
- Weapons at home removed/secured
- Other means removed/limited
- Others may be involved (Command, family/friends)

There...

- **Impossible to Restrict Means**
- Total removal not feasible
- Remove firing pin/bolt/ammo
- Does not *really* remove access
- Other highly lethal means
- Command involvement essential



SLEEP PROBLEMS

Insomnia

- **Strong relationship between suicide risk and insomnia** (Argargun et al, 1997; Bernet et al, 2005; Fawcett et al, 1990) **& sleep complaints** (Krakow et al, 2011)
 - Even in presence of depression/other factors
- **Veterans: sleep problems related to shorter time to suicide** (Pigeon et al, 2012)
- **Nightmares predict SI** (Bernet et al, 2005)
- **31% of OEF Soldiers reported high/very high concerns about lack of sleep** (MHAT-7, 2010)
 - High levels of combat → higher levels of sleep loss

Managing Insomnia

Here...

- Regulate work-sleep schedules
- **Cognitive-Behavioral Therapy for Insomnia (CBTi;** Morin & Espie, 2004)
- Sleep Hygiene
- Stimulus Control
- **Imagery Rehearsal Therapy for Nightmares (IRT;** Krakow et al, 2001)
- Medications

There...

- Irregular schedules are norm
- Sleep hygiene is relative
- Constant caffeine use
- Uncomfortable environment
- **Stimulus control gets tricky**
- Bed/cot is couch, chair, table, desk, bed
- **Need to get creative with interventions/education**
- One-shot class, adapted guidelines, modified CBTi/IRT
- Meds with strong caution



AGITATION & HYPERAROUSAL

Agitation & Hyperarousal

- Agitation is linked to acute suicide risk
(Lineberry et al, 2007; Balazs et al 2005; Benazzi et al, 2005)
 - Regardless of diagnosis
 - A “warning sign”
- Autonomic arousal/hyperarousal
 - Feeling jumpy or amped up
 - Enhanced by caffeine/nicotine use
 - Often adaptive in deployed environment
 - May contribute to sleep problems

Managing Agitation & Hyperarousal

Here...

- **CBT for underlying condition**
- **Applied relaxation**
- **Biofeedback-assisted relaxation**
- **Cut back or d/c caffeine**
- **Meds as tx option**

There...

- **Lack of BFB equipment**
- **Caffeine may be helpful**
- **Limited time for full CBT**
- **Brief, focused interventions**
- **Reduction of “hyper” arousal**
- **Brief relaxation strategies**
- **Certain meds may be ok**



SOCIAL SUPPORT CHALLENGES

Social Support Challenges

- Decreased belongingness is strongly associated with SI, SA, death (Van Orden et al, 2008; Conner et al 2007, Joiner et al 2006)
- Combat may *increase* belongingness
 - Battle Buddy/Wingman/Brothers-in-Arms
- Combat may *decrease* belongingness
 - Separation from family/friends
 - Some do not deploy in units (i.e. USAF)
 - Challenges with loved ones
- Erratic connectivity/communication access
- Feeling disconnected (Ruscio et al, 2002)

Managing Social Support Challenges

Here...

- **Easy access to social network**
- **More time for socializing**
- **Can be targeted in treatment**
- **Crisis response plan includes talking to specific people**

There...

- **Difficult to increase socialization**
- **Skype/calls/emails may intensify distress**
- **Social environment can buffer/manage risk**
- **One-to-Ones unique to deployed setting**
- **“Unit Watch” via commanders**
- **Battle Buddies as escorts (use with caution; Payne et al, 2008)**



UNCLEAR MOTIVATION

Unclear Motivation

- Difficult to determine true motivation
 - Faking bad
 - Frustrating to command: discipline vs. CSR
 - Maybe it is “acting out”...severe implications in a combat zone
 - Faking good
 - Perhaps more prevalent?
 - Stigma/fears of repercussion/duty limitations
 - Suicide risk is not dichotomous
 - Suicide is impossible to predict

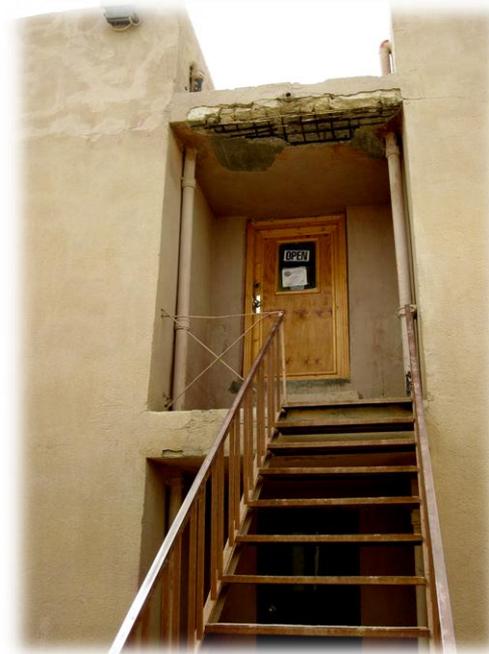
Managing Unclear Motivation

Here...

- **Less pressure to fake good or fake bad...?**
- **Poor functioning not necessarily impacting work**
- **Special assessments to detect over-reporting/inconsistent reporting and malingering-like behavior**

There...

- **Limited access to effort tests**
- **“Faking bad” may lead to huge problems**
- **Those “faking good” may have red flags**
- **Command, buddies have visibility on functioning**
- **“Risk assessment” by leaders**
- **Know your people/know the signs**



DECREASED ACCESS TO SERVICES

Decreased Access to Services

- Full spectrum of care is unavailable
 - No inpatient psyc, substance abuse/dependence, partial hospitalizations, restricted formularies
 - Unequal distribution of CSC/MH services
- #1 reason: Difficult to get time off of work
(MHAT-7, 2010)
- Restricted transportation
 - 30% of deployed cite as inconvenient to access (MHAT-7, 2010)
 - Unsafe/inconsistent travel for members and providers

Managing Decreased Access to Services

Here...

- All bases/posts have some mental health care
- Minimal transportation challenges
- Work with patients & command to resolve barriers
- High-risk patients obtain correct level of care
- Detox, psychiatric inpatient hospitalization, full formulary available

There...

- Providers visit smaller FOBs
- Members may be A/E'd due to lack of care options
- Must balance mission and individual member risk
- Creative options exist
- Pull from missions/frequent check-ins and re-evals
- R & R timeframe adjustment as feasible



COMBAT EXPOSURE

Combat Exposure

- Two dimensions of combat:
 - Combat action
 - Aftermath of combat
- Recent research has found that combat action is not associated with suicidal ideation among deployed personnel (Bryan et al., 2012)
 - Indirect link of aftermath to suicidal ideation seems occur after deployment (Bryan et al., 2012)
- Possible role of guilt, shame, and moral injury

Managing Combat Exposure

Here...

- If needed, there are many PTSD treatment options
- Safer environment
- Risk may elevate at home
- Target guilt/shame/moral injury with ESTs

There...

- Advantage to being “in vivo”
- Acute stress/adjustment disorder/circumstance problem more likely
- May be able to target risk factors more immediately
- Remember barriers to seeking treatment
- Need for “treatment” not readily apparent
- Support via TEM/TSR



DAILY HASSLES

Daily Hassles

- Most frequently-reported stressors among deployed personnel
 - Lack of access to MWR facilities
 - Frustrations with “FOBBIT” mentality
 - Non-traumatic annoyances
- Daily hassles during deployment contribute to increased depression and PTSD symptom severity above and beyond combat exposure
(Heron & Bryan, 2012)

Managing Daily Hassles

Here...

- **Use typical coping skills**
- Unwind/relax
- Strive for work-life balance
- Encourage healthy boundaries
- Plenty of recreational activity options

There...

- **Typical coping not feasible**
- **Heightened arousal may lead to lower frustration tolerance with hassles**
- **May lack access to MWR facilities**
- MWR facilities are limited
- **Walk-about/informal advice about coping skills may help**



Suicide Risk Management in Combat Zones

SUMMARY & CONSIDERATIONS

Getting Creative

- Suicidality is marked by impaired problem solving
- Time for *you* to think outside the box
 - “Behavioral activation”
 - Finding control when you have no control
 - Morale-boosting ideas for commanders
 - Accessing social support
 - Strategic napping
 - Strategic caffeine use
 - Brief relaxation strategies
 - Mindfulness exercises
 - *Your ideas??*

Key Points

1. Means restriction not as effective in theater
2. Insomnia, agitation, arousal are common
3. Fully utilize all available resources to manage acute risk
4. Clinical decisions must factor in feasibility of plan and accessibility for member(s)
5. Look for risk factors/train leadership to look for risk factors
6. Adopt a **risk assessment** approach for managing suicide risk in combat zones

Case Example

- E-4 Male is brought to CSC by his battle buddy, followed by his SGT
 - He was overheard on Skype talking to fiancé, “I can’t take it anymore”
 - Battle Buddy said he hadn’t slept at all last night, and has been more irritable than usual
 - Mission tempo is high, with no days off in over a month
 - Your thoughts?



Questions?

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