



**AVIATION
PSYCHIATRY**

**NAVAL AEROSPACE
MEDICAL INSTITUTE**

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CHAPTER ONE



INTRODUCTION TO AVIATION PSYCHIATRY

CDR MARK W MITTAUER

Psychiatry Department Staff

- | | |
|---------------------|--------------|
| ✦ CDR Mark Mittauer | Dept. Head |
| ✦ CAPT Deborah Wear | Psychiatrist |
| ✦ CDR Shirley Ellis | Psychologist |
| ✦ Dr. Carl Davis | Counselor |
| ✦ Mrs. Kay Gravel | Secretary |
| ✦ HM3 Scott Bedell | LPO |

✦ Phone: 850-452-3974/4238 DSN: 922



Enabling Objectives

- ✦ Discuss course format
- ✦ Discuss grading criteria
- ✦ Discuss clinical references
- ✦ Discuss expected competencies



Why Study Aviation Psychiatry?

- ✦ Most aviation mishaps are due to human error (about 75%)
- ✦ Flight Surgeon is the expert on human factors in aviation
- ✦ Aviator's personnel stresses and psychiatric problems can have major impact on safe completion of the mission



Course Format

- ✦ Didactic lectures
- ✦ Afternoon seminars (4 sessions for each of three groups of students)



Examinations

- | | |
|--|-----|
| ✦ Case vignettes exam (4 cases) | 60% |
| ✦ Video interview and written psychiatric report | 30% |
| ✦ Clinic participation | 10% |



References

- ✦ DSM-IV (Diagnostic and Statistical Manual of Mental Disorder, 4th edition)
 - ✦ Handbook of Aviation Psychiatry (1998)
 - ✦ Kaplan and Sadock - Comprehensive Textbook of Psychiatry, 7th edition
- Note: Pocket Handbook of Clinical Psychiatry



References (cont.)

- ✦ 1997 Aeromedical Reference and Waiver Guide
- ✦ NOMI Code 21 (Psychiatry) Website
<http://www.nomi.navy.mil>
note: select departments/Code 21/lectures



Expected Flight Surgeon Competencies

- ✦ Knowledge of common psychiatric diagnoses
- ✦ Knowledge of human factors in aviation
- ✦ Perform psychiatric evaluation
- ✦ Decide psychiatric diagnoses
- ✦ Decide aeromedical disposition (PQ/NPQ, AA/NAA)



Competencies (cont.)

- ✦ Decide general duty disposition (fit/unfit, suitable/unsuitable)
- ✦ Prepare written psychiatric report
- ✦ Know when to refer patient to Psychiatry



The Boxer Law Instruction

CDR Mark Mittauer
NOMI Psychiatry Department

References

- ✦ DoD Directive 6490.1 (1 Oct. 1997)
- ✦ DoD Instruction 6490.4 (28 Aug. 1997)
- ✦ SECNAV INSTRUCTION 6320.24A (16 Feb. 1999)



Point Of Contact

- ✦ Command JAGC Officer
- ✦ LCDR Mike Bundy (BUMED JAGC Officer)
DSN: 762-3089/6
Comm.: 202-762-3089/6
- ✦ Local Mental Health Department
- ✦ NOMI Psychiatry: DSN: 922-3974
Comm.: 850-452-3974/4238
email: code210@nomi.med.navy.mil



Purpose

- ✦ Prescribe guidance regarding:
 - command-directed mental health evaluations (routine and emergency)
 - involuntary psychiatric hospitalization
 - assessing risk for dangerous behavior
- ✦ Protects rights of service members referred by CO for mental health evaluations



To What Does the Boxer Instruction Apply?

- ✦ Command-directed referrals
- ✦ Clinician suggests mental health evaluation and patient agrees (both have same CO)
- ✦ Involuntary referrals by clinicians
- ✦ Active duty military members
- ✦ DoN civilian employees
- ✦ Reservists on active duty for training



Boxer Instruction does not apply for:

- ✦ Patient requests mental health evaluation (voluntary self-referral)
- ✦ Referring clinician and patient have different CO
- ✦ Competency for duty evaluations
- ✦ Family Advocacy evaluations



Boxer Instruction does not apply for:

- ✦ Substance abuse treatment evaluations
- ✦ Referral to mental healthcare provider for routine screening as mandated by certain instructions (BUMED INST. 5300.8 requires annual evaluations to maintain waivers for alcohol-abusing aviators)
- ✦ Mental competency evaluations
- ✦ Special duty evaluations (submarine)



Scenarios

- ✦ What about non-mental healthcare clinicians performing mental health evaluations?
- ✦ What if the patient and the referring clinician have the same CO - and the patient freely consents to have a psychiatric evaluation *suggested by the clinician?*



Procedures for Non-emergency Evaluations



Commanding Officer Actions (Non-emergency, CO-directed)

- ✦ Consult with mental healthcare provider (psychiatrist, psychologist, doctoral-level social worker) about reason for referral
note: speak to any clinician if mental healthcare provider not available
- ✦ Send memo to CO of MTF/clinic to request a mental health evaluation (encl. (2))
- ✦ This memo must include - ASVAB scores, summary of performance evaluations, past and pending legal actions



Commanding Officer Actions (cont.)

- ✦ CO of MTF to which the patient is attached sends the memo to the Mental Health Department Head
- ✦ Emergency referral: The memo must be sent ASAP by FAX, overnight mail, or courier - "as soon as is practicable"



Commanding Officer Actions (cont.)

- ✦ Give the member a memorandum (encl. (3)) (at least two business days before the appointment) that includes:
 - behavior that led to the referral
 - name of provider consulted
 - list of patient rights
 - date, time, and place of appointment



Patient's Memorandum (cont.)

- ✦ Title and phone number of other authorities (military attorney, IG, chaplain, etc..) with whom the member can discuss the referral
- ✦ The member must sign the memo. or the CO must explain the reason
- ✦ The memo. must be signed by the CO -but may be delivered by others to the patient



Patient's Memorandum (cont.)

- ✦ The memorandum must be provided to both the service member and the mental healthcare provider
- ✦ Enclosure (3) is a "go-by" for the memorandum given to the patient



The Patient's Rights

- ✦ Right to consult a military attorney about how to seek redress - if he questions the referral
- ✦ Right to complain to an IG if he feels the referral was a reprisal
- ✦ Right to select a mental healthcare provider for a second opinion (at own expense usually within 10 business days)



The Patient's Rights (cont.)

- ✦ Right to consult an IG, attorney, congressman, or others - about the referral
- ✦ Right to have two business days before the appointment to consult someone



What if the Commanding Officer cannot comply?

- ✦ The reason must be stated in the request for evaluation
- ✦ Examples:
 - member deployed (no JAGC officer)
 - mental healthcare provider cannot be reached
 - ship sails in less than two days



Mental Healthcare Provider Actions

- ✦ Determine if the procedures for referral were followed
- ✦ If suspect improper referral - first contact the referring CO for clarification
- ✦ If confirm that the referral was improper - report this to your CO
- ✦ Before the interview - advise the patient of the "purpose, nature, and likely consequences" of the evaluation



Mental Healthcare Provider Actions (cont.)

- ✦ Advise the patient that the evaluation is not confidential
- ✦ Advise the patient if you will both evaluate and provide therapy for the patient



Mental Healthcare Provider Actions - after the evaluation

- ✦ Send memorandum (encl. (4)) to patient's CO:
 - summary of findings
 - diagnoses (Axis I,II,III)
 - recommendations (PEB, admin. sep.)
 - degree of dangerousness
 - recommendations to CO on how to handle potentially dangerous patient
 - follow-up appointment date
 - treatment plan



Emergency Mental Health Evaluations



Emergency Evaluations

- ✦ Definition: the member threatens imminently to harm himself, others, or destroy property (that will cause injury)
- ✦ Examples: suicidal, homicidal, unable to care for himself



Commanding Officer Actions (Emergency Evaluation)

- ✦ CO must try to consult a mental healthcare provider first
- ✦ CO must “safely convey” member to a mental healthcare provider
- ✦ CO gives member the memo. “as soon as is practicable” (encl. (3))
- ✦ CO sends memo. requesting the evaluation to provider ASAP (by FAX, overnight mail, courier) (encl. (2))



Mental Healthcare Provider Actions

- ✦ Same as in previous slides:
 - determine if the procedures for referral were followed
 - advise the patient about the purpose and consequences of the evaluation
 - send the patient’s CO a memorandum that includes disposition recommendations



Involuntary Psychiatric Hospitalizations

- ✦ Detailed guidelines in the Instruction
- ✦ Independent psychiatric review within 72 hours of admission - to determine if continued involuntary hospitalization is indicated
- ✦ Independent psychiatric review at least every 5 business days



Imminently or Potentially Dangerous Service Members



Imminent Dangerousness

- ✦ Definition: A member is at substantial risk of committing an act in the near future - which would result in serious injury to himself or others - and has the intent and ability to carry out the action
- ✦ Examples:
 - suicide
 - homicide
 - destruction of property injuring others



Commanding Officer Actions (Imminent Dangerousness)

- ✦ Refer for a mental health evaluation "as soon as is practicable" when the member intends to cause serious injury to himself or others and is likely to cause the injury and the CO thinks he has a *serious mental disorder*.
ex., *not* antisocial behavior
- ✦ First, attempt to consult a mental healthcare provider (or other clinician, if the former is not available)



What if a provider feels that a patient is imminently dangerous?

- ✦ Refer to a privileged mental healthcare provider
- ✦ The patient must be seen within 24 hours
- ✦ The CO must protect the patient and potential victims - prior to the evaluation



Medical Record Documentation (Imminent Dangerousness)

- ✦ The privileged mental healthcare provider shall document:
 - risk for imminent dangerousness
 - treatment plan
 - progress of treatment
 - discharge assessment
 - recommendations to CO
 - notification of potential victims



Healthcare Provider's Duty to Protect

- ✦ Applies to case where patient makes an explicit threat to seriously injure a "clearly or reasonably identifiable person" (directly or through destruction of property) and the patient has the intent and ability to carry out the threat
- ✦ **THIS APPLIES TO FLIGHT SURGEONS, AND NOT JUST PSYCHIATRISTS AND PSYCHOLOGISTS!**



Required Protection Actions May Include:

- ✦ Notify the patient's CO that pt. is dangerous
- ✦ Notify police (where injury will occur)
- ✦ Notify potential victims
- ✦ Recommend appropriate precautions to the CO (restrict patient; deny access to weapons)
- ✦ Hospitalize on psychiatric or medical ward
- ✦ Medical board
- ✦ Recommend administrative separation for personality disorder



Documentation

- ✦ Document the previous actions in the medical record
- ✦ Discuss with the member the clinical summary, memorandum, and the specific recommendations made to the CO



Mental Healthcare Provider Memorandum (Encl. (4))

- ✦ Must be sent to the CO "immediately" after the evaluation for imminent dangerousness
- ✦ Mention diagnosis, prognosis, treatment plan, fitness and suitability for continued service, statement of dangerousness, administrative recommendations (admin. sep. for PD)
- ✦ Include precautions for the CO if the patient was deemed dangerous



Administrative Separation Recommendation

- ✦ When the recommendation is for expeditious administrative separation for personality disorder due to imminent dangerousness - the mental healthcare provider's CO shall cosign the recommendation



Commanding Officer Actions

- ✦ When the CO receives a recommendation about an imminently dangerous member - the CO shall document in writing *actions taken and reasons*



Commanding Officer Actions (cont.)

- ✦ If the recommendation is for expeditious administrative separation for personality disorder and the CO elects not to comply ...
- ✦ The CO shall send a memorandum to his CO explaining why the member will be retained against medical advice (within two business days)



In Summary ... Changes from SECNAVINST 6320.24

- ✦ Referring CO must send the mental healthcare provider (via his CO) a memo with the reason for the referral, etc.
- ✦ Mental healthcare provider must send a memo back to the patient's CO with diagnosis, recommendations, etc.
- ✦ In cases of imminent dangerous - the provider must recommend precautions for the CO to take



Changes (cont.)

- ✦ If the mental healthcare provider recommends administrative separation for personality disorder due to imminent dangerousness - the CO must initiate discharge within 2 days - or explain to his CO why he is ignoring the advice
- ✦ In cases of threatened injury - the provider has precautions he must take



Questions?



Finis



CHAPTER TWO

Psychiatric Standards, etc. A Brief Overview

CAPT D. Wear-Finkle, MC, USN
NOMI Psychiatry Department

Terminal Objectives

At the completion of this lecture the student will:

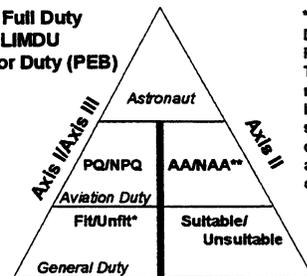
- Understand the different standards for aviation vice general duty
- Differentiate between how Axis I/III vice Axis II conditions are addressed
- Be conversant in the general guidelines for psychiatric standards
- Understand the concept of "NAA"

Enabling Objectives

- Describe the three possible "fitness" determinations and their implications
- Explain how Axis II pathology is addressed in aviation and general duty
- Provide an example of a condition that may render someone fit for full duty but NPQ for aviation
- Discuss the proper application of the acronyms, CD and NPQ

PHYSICAL STANDARDS

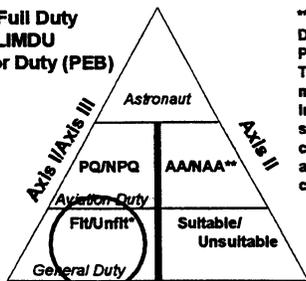
*Fit for Full Duty
Fit for LIMDU
Unfit for Duty (PEB)



**Personality Disorders or Personality Traits that are maladaptive and impair flight safety, mission completion, or aircrew coordination

PHYSICAL STANDARDS

*Fit for Full Duty
Fit for LIMDU
Unfit for Duty (PEB)



**Personality Disorders or Personality Traits that are maladaptive and impair flight safety, mission completion, or aircrew coordination

Physical/Psychiatric Fitness

- For general duty:
 - Fit for full duty
 - Fit for LIMDU (6-12 months) - requires a limited duty medical board by the specialist with the limitations specified
 - Unfit for duty - requires a medical board sent to the Physical Evaluation Board (PEB) in Arlington, VA - usually done for severe illnesses/injuries or after period of LIMDU fails to restore the member to full duty

LIMDU Examples

- Major Depression
- Obsessive Compulsive Disorder
- Panic Disorder
- Minor Axis I Disorders may not need a LIMDU board - depends on type of treatment, severity of symptoms, duty station, deployment status, etc.

PEB Examples

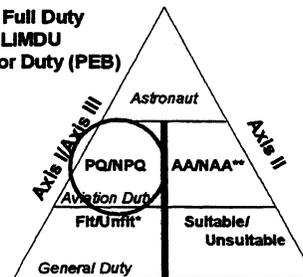
- Schizophrenia
- Manic Depressive D/O
- Recurrent Major Depression - severe
- Refractory anxiety disorders
- **CAVEAT:** Just because the specialist recommends the member is unfit for further military service is **NO** guarantee the member will be medically discharged

FYI

- **EPTE** - existed prior to enlistment
- **DNEPTE** - did not
- **SA** - service aggravated
- **NSA** - not

PHYSICAL STANDARDS

*Fit for Full Duty
Fit for LIMDU
Unfit for Duty (PEB)



**Personality Disorders or Personality Traits that are maladaptive and impair flight safety, mission completion, or aircrew coordination

Standards for Special Duty (including aviation)

- Member must be fit for full duty
- Member must have NO diagnoses for the special duty that make them *not physically qualified (NPQ)*
- Aviation examples: **ALL AXIS I Disorders** other than Adjustment Disorder and V Codes - MANY are OK for general duty (dysthymia, minor depressive/anxiety disorders, etc.)

NPQ vice CD

- **PEOPLE** are **Not Physically Qualified**
- **DISEASES/CONDITIONS** are **Considered Disqualifying**
(waivers are for CD conditions)

Examples

- Someone with ETD from a URI may be **NPQ for the duration of the cold, but a URI is NCD**
- If the ETD is from chronic sinusitis, the person will be **NPQ from a condition that is CD**
- Even when the ETD resolves, the person will remain NPQ as the condition is CD (and need a waiver)

Examples (cont.)

- If someone has insomnia secondary to a work schedule or marital discord, they will be **NPQ until the insomnia resolves**
- If the insomnia is from a Major Depressive Disorder, they are **NPQ and the condition is CD**
- Once symptoms of depression are resolved, the person will remain NPQ as the condition is CD (and need a waiver)

*You don't need a waiver
if the condition is not
considered disqualifying*



WAIVERS for Psych Diagnoses

- **For the majority of diagnoses:**
 - 1 year off meds, out of treatment, symptom-free
- **NO waivers for psychotic illnesses**
- **Adjustment Disorders/V Codes** - no waiver required
- **PDs - no waiver possible** (in special cases re-eval in 2-3 years)

PHYSICAL STANDARDS

*Fit for Full Duty
Fit for LIMDU
Unfit for Duty (PEB)



**Personality Disorders or Personality Traits that are maladaptive and impair flight safety, mission completion, or aircrew coordination

Suitability

- Refers to a personality disorder (PD) diagnosis and the person's conduct/performance (**SECNAVINST 1910.4B**)
- The PD must be diagnosed by a psychologist/psychiatrist
- If that PD is of such severity that it will interfere with the member's performance of duty or pose a threat to their/others safety, then;

Suitability (cont.)

- they may be deemed “*unsuitable for further military service,*” and:
 - recommended for expeditious administrative separation as a continuing risk for harm to self and others
- recommended for adsep only or no recommendation:
 - a page 13 service record entry is made **IAW MILPERSMAN 1910-202**

Other Reasons for ADSEP

- for conditions not necessarily amounting to disability
 - somnambulism
 - enuresis
 - motion/air sickness
 - allergies
 - excessive height
 - anorexia nervosa
 - bulimia nervosa
 - non-resolving physical or medical problems which regularly prevent PRT participation

Other Reasons for ADSEP

(a page 13 required)

- Convenience of the Government (COG) - parenthood
- COG - Personality disorder
- entry level performance and conduct
- weight control failure
- unsatisfactory performance
- misconduct - a pattern of misconduct
- misconduct - minor disciplinary infractions

Mandatory ADSEP

- Sexual Harassment
- Misconduct - civil or military that could result in death or serious bodily injury
- Misconduct - civil conviction for offenses that could result in death or serious bodily injury
- Misconduct - drug abuse
- Homosexual conduct
- Supremacist/Extremist conduct
- Weight Control Failure

Don't confuse the REASON for discharge with the TYPE of d/c

- Honorable
- General
- Other than Honorable (OTH)
- Bad Conduct Discharge (BCD)
- Dishonorable Discharge (DD)

PHYSICAL STANDARDS

*Fit for Full Duty
Fit for LIMDU
Unfit for Duty (PEB)



**Personality Disorders or Personality Traits that are maladaptive and impair flight safety, mission completion, or aircrew coordination

AA as a concept

- 1916-1920: AA was known as "non-physical standards for aviation"
- interim - ill defined and often based on whim of evaluator
- definition of NAA after 1992: *"The existence of a personality disorder or traits that are maladaptive to mission completion, safety of flight, or aircrew coordination"*

AA (cont.)

- **AERONAUTICALLY ADAPTABLE** - reserved for candidates and students in aviation
- **AERONAUTICALLY ADAPTED** - a term reserved for designated aviators and aircrew

AA (cont.)

AA is *implied* by having the adaptability to the rigors of aviation by possessing the temperament, flexibility, and mature defense mechanisms to allow for full attention to flight and successful completion of training (in case of students) or tolerate the stress of operational training and deployment, and long-term use of mature defense mechanisms.

In reality, what we are stating when we say someone is "AA" is that there is no evidence they are NAA

If you think someone is NAA:

- Collect your data
- refer to psych (diagnosis *must* be made by psychologist or psychiatrist)
REMEMBER BOXER requirement
- **Call us** - if a junior person with PD just send it in. All officers and senior enlisted (or others who don't agree) need to come to NOMI
- EMAIL us - for *anything*

Anyone on Flight Status Needs Both an Aviation and General Duty Recommendation

- **PQ and AA**
- **Fit and Suitable**

Higher Standard for Aviation

- You can be NPQ and NAA but. . .
- Fit and Suitable for general duty
- for example:
 - Sinusitis with a mild PD
 - Dysthymia with Dependent Personality Traits



ADMINISTRATIVE SEPARATION GUIDE

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Enclosure (2)

SECNAVINST 1910.4B

29 MAY 1996

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CHAPTER THREE

Substance Related Disorders

TERMINAL OBJECTIVE

- Upon completion of this period of instruction, the SUPERIOR SFS will accurately distinguish between the diagnoses of alcohol abuse and alcohol dependence, and make recommendations for aeromedical disposition IAW current USN directives and standards

ENABLING OBJECTIVES

- State the DSM-IV criteria differentiating alcohol abuse from alcohol dependence
- Describe the aeromedical disposition of aviation personnel on flight status diagnosed with a substance use disorder
- List the minimum documentation required in an acceptable waiver package

Psychoactive Substance Use **OPIOIDS**

- > 600,000 addicts in the U.S.
- > Route of administration:
 - oral
 - smoked
 - nasal inhalation
 - IV or SC ingestion
- > Dosage easy to underestimate

Substance Use in the General Population

(Use more than once before age 25)

- > Alcohol - 95%
- > Marijuana - 64%
- > Cocaine - 28%
- > Hallucinogens - 20%

OPIOIDS

- > **Intoxication Symptoms**
 - drowsiness
 - respiratory depression
 - euphoria
 - pupillary constriction
- > **Withdrawal Symptoms**
 - nausea/vomiting
 - sweating
 - pupillary dilation
 - piloerection



STIMULANTS
(Cocaine, Amphetamines)

- Extremely addicting
- Route of administration:
 - oral
 - smoking/snorting
 - IV
- Binge use



STIMULANT INTOXICATION

- restlessness
- pressured speech
- paranoid ideation/delusion
- increased pulse/BP
- pupillary dilation
- tactile/olfactory hallucinations



STIMULANT WITHDRAWAL

- “CRASH”
- lethargy
- prolonged sleep
- craving
- depression (1-2 months)



HALLUCINOGENS

- Most Commonly:
 - eaten
 - sucked off paper
 - smoked



HALLUCINOGEN INTOXICATION

- ANXIETY/DEPRESSION
- depersonalization
- hallucinations/illusions
- sweating/tremors
- palpitations



HALLUCINOGEN WITHDRAWAL

- PANIC REACTION
- Treatment:
 - reassurance
 - secure environment
 - benzodiazepines/antipsychotics

ALCOHOL

- 50% of males between ages 18 and 25 will have one ETOH-related incident
- 10 million alcoholics in the US
- 10% of drinking population consumes 50% of all alcohol
- male:female prevalence is 4:1

ALCOHOL (cont.)

- 35+% of all suicides are ETOH-related
- 41% of all traffic fatalities are “ “
- 20% of all ER visits are ETOH-related
- AA attendance gives 50% better chance for one year sobriety
- successful *controlled drinking* no longer a valid concept

ALCOHOL (cont.)

- 1 in 10 deaths in the United States is alcohol-related
- 20-25% of all hospital inpatients are alcoholic
- conservative estimate is 1 in 10 ambulatory patients is alcoholic

ALCOHOL'S EFFECTS

- 4 drinks in a 2-hour period raises the BAL to *AT LEAST* 0.08 (DUI cutoff)
- BAL of 0.05 affects judgment and fine motor activity
- acute and 8 hour effects of 0.08 BAL in simulator performance
- rule of thumb - metabolize 0.015/h (up to 0.025/h in a heavy drinker)

Relationship of #DUIs to diagnosis of alcoholism



- 1st - 75%
- 2nd - 90%
- 3rd - 100%

ALCOHOL'S EFFECTS (cont.)

- disinhibition
- regression
- impulsivity
- grandiosity
- decreased frustration tolerance
- passivity

DSM-IV Diagnosis of **Substance Abuse**

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

DSM-IV Diagnosis of **Substance Abuse (cont.)**

- Recurrent substance use **resulting in a failure to fulfill major role obligations**
- Recurrent substance use in situations where it is **physically hazardous**
- Recurrent substance-related **legal problems**
- **continued substance use despite** having persistent or recurrent social or interpersonal **problems** caused by or worsened by the effects of the substance

DSM-IV CRITERIA **SUBSTANCE DEPENDENCE**

- A maladaptive pattern of use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

Substance Dependence (cont.)

1. **tolerance** (needing more to achieve intoxication or desired effect, or diminished effect with continued use of same amount)
2. **withdrawal**
3. often uses **more than intended**
4. persistent desire or unsuccessful attempts to **cut down or control use**
5. great deal of time **getting/using/recovery**
6. important activities given up or reduced because of using
7. continued use **despite problems**

Alcohol Dependence Diagnosis

- The diagnosis requires skillful interviewing and careful analysis of data
- TWO CARDINAL FEATURES:
 - **DENIAL**
 - EVIDENCE OF INABILITY TO CONTROL DRINKING

Breaking Through Denial

- **CONFRONTATION**
- **SHOWING EMPATHY**
- **OFFERING HOPE**

CAGE TEST

- C** - Concern for drinking/attempts to Cut down
- A** - Annoyed at advice/comments
- G** - Guilt over use/behavior while using
- E** - "Eye openers"

RISK FACTORS IN SUBSTANCE ABUSE

- FAMILY HISTORY (sons of alcoholic fathers)
- AXIS I Psychiatric Disorders (manic depressive disorder)
- AXIS II Personality Disorders/Traits (antisocial, borderline, avoidant)

THE ENABLING HEALTH CARE PROVIDER

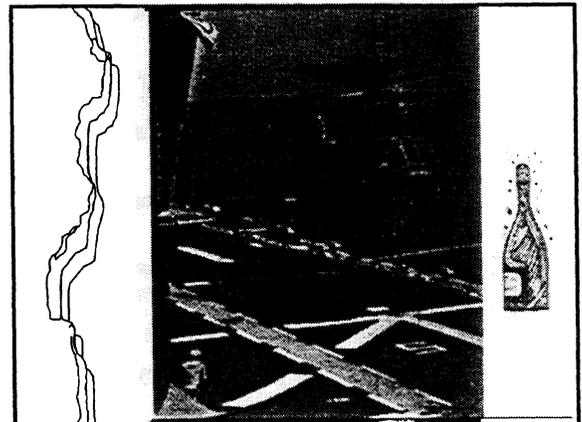
- Failure to diagnose alcoholism
- failure to treat alcoholism as a primary disease
- treating the alcoholic with sedatives or tranquilizers
- treating the co-alcoholic with sedatives or tranquilizers

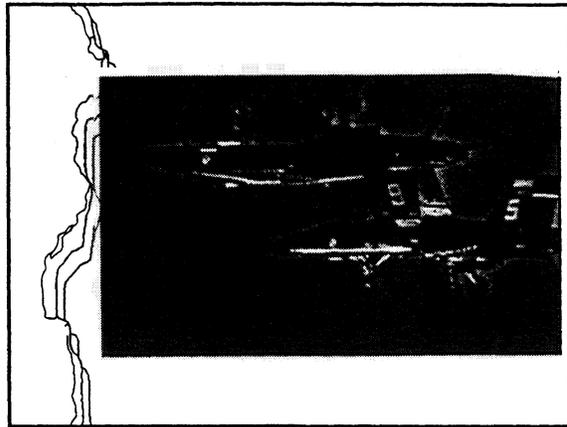
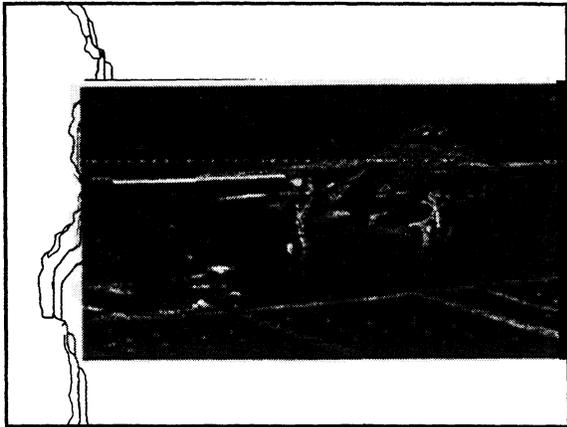
Alcohol and the Aviator



NATOPS 3710.7

Any form of alcohol intake within 12 hours prior to flight planning is prohibited. Flight crews shall ensure that they are free of hangover effect prior to flight. Detectable blood alcohol or symptomatic hangover is cause for grounding of flight personnel.





BUMED INST 5300.8
ALCOHOL ABUSE/DEPENDENCE

- ✦ *Ground immediately!*
- ✦ *NPQ and AA* all aviation duty
- ✦ Submit grounding PE
- ✦ FS tasked with diagnosis and referral to treatment

BUMEDINST 5300.8 (cont.)
Waiver request based on FS assessment of:

- ✦ Positive attitude and *UNQUALIFIED ACKNOWLEDGMENT* of diagnosis
- ✦ Successful completion of program and favorable prognosis
- ✦ *ABSTINENCE !!!!*
- ✦ *Documented AA*



BUMEDINST 5300.8 (cont.)

Return to flight status/aviation related duty:

- Normally 90 days after successful treatment
- No sooner than 30 days (<90 only if absolutely mission-essential)
- FS can extend to 12 months
- Service Group limitations not specified

(Former) NAVY ALCOHOL TREATMENT PROGRAM

LEVEL I: PREVENT

LEVEL II: CAAC - 2-3 week structured program for substance abuse

LEVEL III: ARS/ARC - 4-6 week inpatient program for substance dependence

New Navy Alcohol Treatment

- **Level 0.5 - IMPACT**
- **Level I - (OP)** - meets criteria for ETOH Abuse
- **Level II - (IOP)** - meets criteria for ETOH Dependence
- **Level III** - Dormitory (when 24h tx needed)
- **Level IV** - Medical risk of withdrawal
- **Continuing Care** - the basis of relapse prevention and recovery

New Navy Alcohol Treatment (cont.)

- **IOP lasts 1-2 weeks**
- **Philosophy of treatment:**
 - pts must learn a program of self-management, to cope with sobriety/responsible consumption, emotional stress, and/or physical cravings associated with alcohol
 - this includes a new social network and knowledge to develop alternatives to and derive pleasure from substance-free activities.

The Goal of Successful Treatment

- **ABSTINENCE:** when a program is adhered to for 3 years there is a 70% recovery rate
- **NEVER** support "*controlled drinking*" as a goal for an alcoholic



BUMEDINST 5300.8 (cont.) Waiver Package

- SF 88/93/NAVMED 612012
- **PSYCHIATRIC EVALUATION**
 - initially
 - annually in aftercare
- Internal medicine eval "as indicated"
- Copy of Level II/III/IOP Treatment Summary (1st time only)

BUMEDINST 5300.8 (cont.) Waiver Package

- **FS NARRATIVE** addressing:
 - work performance
 - peer relationships
 - family/marital/SO/relationships
 - psychosocial stressors
 - attitude towards recovery
 - abstinence
 - AA attendance
 - MSE
- DAPA's statement to document aftercare

BUMEDINST 5300.8 (cont.) Interval for Flight PEs

- Upon completion of treatment with waiver submission
- Annually thereafter

BUMEDINST 5300.8 (cont.) Aftercare Requirements

- **FS visit:** monthly (1st year); quarterly (2nd and 3rd years)
- **DAPA visits:**
 - monthly for 3 years
 - documented AA
- **AA (or other organized recovery program*)**
 - 3x/week for 1st year
 - 4x/month thereafter

* *not recommended*

Relapse

- Command **MUST** submit request for revocation of waiver
- We will consider (case-by-case) if a second waiver will be recommended - usually don't even consider submission for 12 months after re-eval, retreatment, and aftercare back at beginning
- Severity of relapse and evidence of recovery governs decisions

Predictors of Good Future Capability *(useful for special evals)*

- no family history of substance abuse or mental illness
- lack of disciplinary/legal problems
- no personal psychiatric history
- positive life goals and plans
- one year of abstinence

Comparison of Service/FAA Alcohol Policies

- None distinguish abuse from dependence
- **Minimum** down time:
 - USA: 6 months
 - USAF: 60 days
 - USN: 30 days
 - FAA: 90 days
- **All require total abstinence**
- Aftercare emphasis - USN and FAA only



Visiting Professional Program

In past all FSs went en route to their first duty station as a flight surgeon.

No current mechanism formally (\$\$\$)



If you have not had this experience during internship/residency/life please request to attend the four-day program on base at the ATC or as soon as possible at your duty station

SUMMARY

- USN still most liberal in return to flying
- Substance Abuse/Dependency is not a disease of "*spontaneous insight*"
- Physicians must be better educated
- Alcohol use is not a "right" - like flying, it is lost when it is abused

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Washington, DC 20372-5120

BUMEDINST 5300.8
BUMED-23
20 March 1992
W/ 2 MSG changes/updates

BUMED INSTRUCTION 5300.8

From: Chief, Bureau of Medicine and
Surgery

To: All Ships and Stations

Subj: DISPOSITION OF REHABILITATED
ALCOHOL DEPENDENT OR
ABUSER AIRCREW, AIR CONTROL-
LERS, HYPOBARIC CHAMBER
INSIDE OBSERVERS AND
INSTRUCTORS

Ref: (a) SECNAVINST 5300.28B
(b) OPNAVINST 5350.4B

1. Purpose. To provide guidance for the uniform disposition of aviators, aircrew, air traffic controllers, and hypobaric chamber inside observers and instructors who have been diagnosed as alcohol dependent or alcohol abusers.

2. Cancellation. NAVMEDCOMINST 5300.2.

3. Scope. Applies to all commands and activities having aircrew personnel, air controllers, and hypobaric chamber inside observers or instructors within their administrative control.

4. Background. The Navy recognizes that alcoholism is treatable and has established programs emphasizing individual participation in treatment and rehabilitation. Within the constraints imposed by flight safety regulations, appropriate Federal Aviation Administration (FAA) regulations, and all pertinent Chief of Naval Operations (CNO) and Bureau of Medicine and Surgery (BUMED) directives, these individuals should be returned, as expeditiously as possible, to their special duty assignments, per reference (a). The uniform disposition of rehabilitated aviation personnel throughout the naval aviation communities should be commensurate with operational requirements.

5. Applicability. Applies to all aeronautically designated personnel or students (Navy and Marine Corps), active and Reserve, serving in a flying status involving operational or training flights (DIFOT), duty in a flying status not involving flying (DIFDEN) orders, those personnel serving as hypobaric chamber inside observers or instructors under hazardous duty incentive pay (HDIP) orders, and to all civilian employees of the Department of the Navy, including nonappropriated fund employees and contract employees involved with frequent aerial flights or air traffic control duties.

6. Action

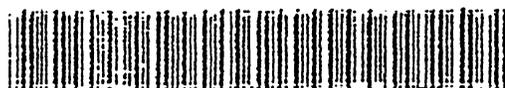
a. Personnel diagnosed as alcohol dependent or alcohol abusers using current Diagnostic and Statistic Manual (DSM) criteria must be grounded immediately and found not physically qualified (NPQ) for all aviation duty. The diagnostic criteria should conform to the most current DSM of the American Psychiatric Association.

*MSG 181300Z JAN 94 Aviation personnel diagnosed as alcohol dependent prior to 1987 or as alcohol abusers prior to 20 MAR 92 need to be identified and shall be subject to this instruction.

(1) Personnel diagnosed as alcohol dependent by a flight surgeon, other medical officer, or clinical psychologist must be immediately referred to a Level III inpatient program for treatment.

(2) Personnel diagnosed as alcohol abusers and judged by a flight surgeon, other medical officer, or clinical psychologist not to be dependent must be immediately referred to a command alcohol counseling center Level II program for treatment per reference (b).

c. Upon satisfactory completion of the appropriate treatment program, personnel must be evaluated by a flight surgeon. (Aviation medical examiners under competent orders are used synonymously under the collective title flight



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surgeon throughout this instruction.) Those diagnosed as alcohol dependent and alcohol abusers are to be considered NPQ for aviation duties. Return to flight status requires a waiver for such duty from the Chief, Bureau of Naval Personnel or Commandant of the Marine Corps.

d. A recommendation for return to flight status, air controller duties, or hypobaric inside observer or instructor duties rests on a positive assessment by the flight surgeon. The flight surgeon must consider the following areas when making a recommendation:

(1) Member's positive attitude and unqualified acknowledgement of his or her alcohol disorder.

(2) Successful completion of the appropriate treatment program with favorable prognostic statement by the treatment facility.

(3) Abstinence from alcohol.

(4) Satisfactory participation in an ongoing program of recovery. The flight surgeon and squadron drug and alcohol program advisor (DAPA) must document required visits. The member must provide proof of attendance at Alcoholics Anonymous (AA) or other organized outpatient alcohol recovery program.

e. Aftercare Intervals. The member must visit the following professionals and organizations at the intervals specified:

(1) Flight Surgeon. Monthly for the first 12 months, then every 3 months for the remaining 2 years.

(2) DAPA. Monthly for the entire 3 years with documentation of AA attendance.

(3) AA. Attended at least 3 times per week for the first 12 months out of treatment, then no less than 4 times per month for the remainder of the documented recovery program. Exceptions to this recovery program schedule for operational necessity must receive command endorsement.

f. All personnel must be given a series of physical examinations specified to provide additional monitoring of the recovery process. Forward all physicals to BUMED (MED-236) located at the Naval Aerospace Medical Institute (NAVAEROSPMEDINST), Naval Air Station, Pensacola, FL 32508-5600. These examinations must include a complete flight physical (SF 88 and SF 93 or NAVMED 6120/2 as appropriate) as well as the following information:

(1) Flight surgeon's narrative assessment of the member's recovery specifically addressing: work performance, peer relationships, family and marital relationships, psychosocial stressors and attitude toward recovery, abstinence, and AA attendance. A mental status examination should be performed with referral to NAVAEROSPMEDINST for specialized neuropsychological testing if there are any questions of cognitive impairment.

(2) Copy of Level II or Level III treatment summary (first time only).

(3) Flight surgeon's and DAPA's statements to document aftercare, including AA attendance. (AA attendance is usually verified by signature card and recorded by command DAPA.)

(4) Psychiatric evaluation by a privileged psychiatrist or clinical psychologist at initial waiver request, then annually while in aftercare. required

(5) Internal medicine evaluation at initial waiver request as indicated. gastritis, ect. (FS rec.)

g. Intervals for performance of flight physicals:

MSG 021300Z FEB 94

~~deleted (1) Immediately upon completion of appropriate treatment program.~~ 1. Submit grounding P.E. upon diagnosis of alcohol dependence or abuse.

MSG 021300Z FEB 94

~~deleted (2) Every 3 months thereafter during the first 12 months of recovery, then at 6-month intervals for the remaining 2 years, and annually thereafter for the duration of the member's~~

~~aviation career.~~ A complete P.E. should be submitted with initial waiver request. Thereafter P.E. for endorsement are required annually for continuance.

(3) Recommendation of return to service group I, service group II, or service group III (class I personnel).

(4) Upon recommendation of return to naval flight officer, aircrew, air traffic controller, or hypobaric inside observer or instructor duties (class II personnel).

(5) Upon subsequent restriction of special duty assignment for any reason.

h. Return to flight status or aviation related duties:

(1) No sooner than 30 days after satisfactory completion of the appropriate treatment program. *II or III*

(2) Those diagnosed as alcohol abusers, providing the criteria in paragraphs 6(d) and (e) are met, may request a waiver to return to class II duties normally after 90 days of demonstrated recovery.

(3) Those diagnosed as alcohol dependent and all class I aviation personnel will normally be returned to aviation duties after at least 3 months of demonstrated recovery and meeting the criteria in paragraphs 6(d) and (e). In cases of continued personal turmoil, emotional instability, or poor adherence to recovery program, the flight surgeon may wish to extend the observation time as long as 12 months. The 30-day option should only be used in those cases with minimum risk factors, minimal family or personal turmoil, and unqualified participation in treatment and recovery.

i. Submit initial waiver requests and flight physical with commanding officer's endorsements and specified consultations and documentation to MED-236 for review.

j. In line with current FAA and Navy and Marine Corps policy, Antabuse therapy is considered to be disqualifying for duty involving flight operations for all personnel who are involved in the conduct and safety of flight.

A minimum of 14 days should lapse after cessation of Antabuse before resuming flying duties.

7. Noncompliance. Continued denial of an alcohol problem and refusal to abstain from alcohol following treatment is unacceptable for continued aviation status in any capacity and requires submission of SF 88 and SF 93 to MED-236. The disease concept of alcoholism, plus potential safety considerations, does not permit a trial of social drinking for an individual with a diagnosis of alcohol dependence or abuse. Refusal to abstain from alcohol requires a recommendation of permanent removal from flight status. Full documentation for such a recommendation must be provided with endorsement by the individual's commanding officer.

8. Forms

a. SF 88 (10-75), Report of Medical Examination, NSN 7540-00-634-4038, and SF 93 (10-74), Report of Medical History, NSN 7540-00-181-8368, are available from the Federal Supply System through normal supply procurement procedures.

b. NAVMED 6120/2 (11-79), Officer Physical Examination Questionnaire, S/N 0105-LF-208-3071, is available from the Navy Supply System and may be requisitioned per NAVSUP P-2002D.

D. F. HAGEN

Distribution:

SNDL Parts 1 and 2
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FM NAVOPMEDINST PENSACOLA FL//42//

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SUBJ/AEROMEDICAL ISSUES 0197//

REF/A/DOC/SECNAV/11JUL90//

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REF/C/DOC/BUMED/20MAR92//

REF/D/DOC/CMC/13DEC96//

REF/E/MSG/NAOMI-42/18JAN94//

REF/F/MSG/NAMI-42/02FEB93//

REF/G/MSG/NAOMI-42/29SEP94//

REF/H/DOC/NOMI-42/12DEC96//

NARR/REF A SECNAVINST 5300.28B. REF B OPNAVINST 5350.4B.

REF C BUMEDINST 5300.8. REF D MCO P5300.12. REF E AIG 139 AEROMEDICAL

ISSUES 0194 MSG/181300Z.JAN94. REF F AIG 139 AEROMEDICAL ISSUES 0193/

MSG 021300Z.FEB93. REF G AIG 139 AEROMEDICAL ISSUES 0394/MSG

291300Z.SEP94. REF H 1997 AEROMEDICAL REFERENCE AND WAIVER GUIDE

NOTAL.//

POC/W. B. FERRARA/CDR/PENSACOLA FL/-/TEL:DSN 922-4501 OR 4502

/TEL:COMM 904-452-4501/TEL:FAX 2708//

RMKS/1. SINCE THE INITIAL RELEASE OF REF C, THERE HAVE BEEN SEVERAL CHANGES TO THE BASIC INSTRUCTION (REFS E,F,G). CURRENTLY, THE ONLY WRITTEN GUIDANCE WHICH INCORPORATES ALL THE CHANGES IS REF H. THIS MESSAGE SERVES AS A RECAPITULATION OF THE BASIC INSTRUCTION WITH THE APPROVED CHANGES PENDING REVISION OF REF C.

SUBJ: DISPOSITION OF REHABILITATED ALCOHOL DEPENDENT OR ABUSER AIRCREW, AIR CONTROLLERS, HYPOBARIC CHAMBER INSIDE OBSERVERS AND INSTRUCTORS.

1. PURPOSE. TO PROVIDE GUIDANCE FOR THE UNIFORM DISPOSITION OF AVIATION PERSONNEL, AIRCREW, AIR TRAFFIC CONTROLLERS AND HYPOBARIC CHAMBER INSIDE OBSERVERS OR INSTRUCTORS WHO HAVE BEEN DIAGNOSED AS ALCOHOL DEPENDENT OR ALCOHOL ABUSERS.

2. SCOPE. APPLIES TO ALL COMMANDS AND ACTIVITIES HAVING AIRCREW PERSONNEL, AIR CONTROLLERS, UNMANNED AERIAL VEHICLE OPERATORS, AND HYPOBARIC CHAMBER INSIDE OBSERVERS OR INSTRUCTORS WITHIN THEIR ADMINISTRATIVE CONTROL.

3. BACKGROUND. THE NAVY RECOGNIZES THAT ALCOHOLISM IS TREATABLE AND HAS ESTABLISHED PROGRAMS EMPHASIZING INDIVIDUAL PARTICIPATION IN TREATMENT AND REHABILITATION. WITHIN THE CONSTRAINTS IMPOSED BY FLIGHT SAFETY REGULATIONS, APPROPRIATE FEDERAL AVIATION ADMINISTRATION (FAA) REGULATIONS, AND ALL PERTINENT CHIEF OF NAVAL OPERATIONS (CNO) AND BUREAU OF MEDICINE AND SURGERY (BUMED) DIRECTIVES, THESE INDIVIDUALS SHOULD BE RETURNED, AS EXPEDITIOUSLY AS POSSIBLE, TO THEIR SPECIAL DUTY ASSIGNMENTS, PER REFERENCE A. THE UNIFORM DISPOSITION OF REHABILITATED AVIATION PERSONNEL THROUGHOUT THE NAVAL AVIATION COMMUNITIES SHOULD BE COMMENSURATE WITH OPERATIONAL REQUIREMENTS.

=====

4. APPLICABILITY. APPLIES TO ALL AERONAUTICALLY DESIGNATED PERSONNEL OR STUDENTS (NAVY AND MARINE CORPS), ACTIVE AND RESERVE, SERVING IN A FLYING STATUS INVOLVING OPERATIONAL OR TRAINING FLIGHTS (DIFOT), DUTY IN A FLYING STATUS NOT INVOLVING FLYING (DIFDEN) ORDERS, AIR TRAFFIC CONTROLLERS, UNMANNED AERIAL VEHICLE OPERATORS, THOSE PERSONNEL SERVING AS HYPOBARIC CHAMBER INSIDE OBSERVERS OR INSTRUCTORS UNDER HAZARDOUS DUTY INCENTIVE PAY (HDIP) ORDERS, AND TO ALL CIVILIAN EMPLOYEES OF THE DEPARTMENT OF THE NAVY INCLUDING NON-APPROPRIATED FUND EMPLOYEES AND CONTRACT EMPLOYEES INVOLVED WITH FREQUENT AERIAL FLIGHTS OR AIR TRAFFIC CONTROL DUTIES.

5. ACTION.

A. PERSONNEL DIAGNOSED AS ALCOHOL DEPENDENT OR ALCOHOL ABUSERS USING CURRENT DIAGNOSTIC AND STATISTIC MANUAL (DSM) CRITERIA MUST BE GROUNDED IMMEDIATELY AND FOUND NOT PHYSICALLY QUALIFIED (NPQ) FOR ALL AVIATION DUTY. THE DIAGNOSTIC CRITERIA SHOULD CONFORM TO THE MOST CURRENT DSM OF THE AMERICAN PSYCHIATRIC ASSOCIATION. THE DSM CRITERIA REQUIRE DOCUMENTATION OF A PATTERN OF MALADAPTIVE BEHAVIOR FOR EITHER A DIAGNOSIS OF ALCOHOL ABUSE OR DEPENDENCE. ALL AVIATION PHYSICAL EXAMS SHALL INCLUDE THE FOLLOWING QUESTION ON THE APPROPRIATE QUESTIONNAIRE (SF-93, 6120/2 OR ABBREVIATED INTERVAL EXAM "SHORTFORM"): "HAVE YOU EVER BEEN DIAGNOSED OR HAD ANY LEVEL OF TREATMENT FOR ALCOHOL ABUSE OR DEPENDENCE."

B. DISPOSITION

1. PERSONNEL DIAGNOSED AS ALCOHOL DEPENDENT BY A FLIGHT SURGEON, OTHER MEDICAL OFFICER OR CLINICAL PSYCHOLOGIST MUST BE IMMEDIATELY REFERRED TO A LEVEL III INPATIENT PROGRAM FOR TREATMENT PER REFERENCES B AND C. LEVEL III TREATMENT IS DEFINED IN REFERENCE B.

2. PERSONNEL DIAGNOSED AS ALCOHOL ABUSERS AND JUDGED BY A FLIGHT SURGEON, OTHER MEDICAL OFFICER, OR CLINICAL PSYCHOLOGIST, NOT TO BE DEPENDENT MUST BE IMMEDIATELY REFERRED TO A COMMAND ALCOHOL COUNSELING CENTER LEVEL II OUT-PATIENT PROGRAM FOR TREATMENT AS PER REFERENCES B AND C. LEVEL II TREATMENT IS DEFINED IN REFERENCE B.

3. AVIATION PERSONNEL DIAGNOSED AS ALCOHOL DEPENDENT PRIOR TO 1987 OR AS ALCOHOL ABUSER PRIOR TO 20 MAR 92 NEED TO BE IDENTIFIED AND SHALL BE SUBJECT TO THIS INSTRUCTION PER REFERENCE D.

C. UPON SATISFACTORY COMPLETION OF THE APPROPRIATE TREATMENT PROGRAM, PERSONNEL MUST BE EVALUATED BY A FLIGHT SURGEON. (AVIATION MEDICAL EXAMINERS UNDER COMPETENT ORDERS ARE USED SYNONYMOUSLY UNDER THE COLLECTIVE TITLE FLIGHT SURGEON THROUGHOUT THIS INSTRUCTION). THOSE DIAGNOSED AS ALCOHOL DEPENDENT AND ALCOHOL ABUSERS ARE TO BE CONSIDERED NPQ FOR AVIATION DUTIES. RETURN TO FLIGHT STATUS REQUIRES A WAIVER FOR SUCH DUTY FROM THE CHIEF OF NAVAL PERSONNEL, OR COMMANDANT OF THE MARINE CORPS.

D. A RECOMMENDATION FOR RETURN TO FLIGHT STATUS, AIR CONTROLLER DUTIES OR HYPOBARIC INSIDE OBSERVER OR INSTRUCTOR DUTIES RESTS ON A POSITIVE ASSESSMENT BY THE FLIGHT SURGEON, WHO MUST CONSIDER THE FOLLOWING AREAS WHEN MAKING A RECOMMENDATION:

1. MEMBER'S POSITIVE ATTITUDE AND UNQUALIFIED ACKNOWLEDGMENT OF HIS OR HER ALCOHOL DISORDER.

2. SUCCESSFUL COMPLETION OF THE APPROPRIATE TREATMENT PROGRAM WITH FAVORABLE PROGNOSTIC STATEMENT BY THE TREATMENT FACILITY.

=====

3. ABSTINENCE FROM ALCOHOL.

4. SATISFACTORY PARTICIPATION IN AN ONGOING PROGRAM OF RECOVERY. THE FLIGHT SURGEON AND SQUADRON DRUG AND ALCOHOL PROGRAM ADVISOR (DAPA) OR UNIT'S SUBSTANCE ABUSE CONTROL OFFICER (SACO) MUST DOCUMENT REQUIRED VISITS. THE MEMBER WILL PROVIDE PROOF OF ATTENDANCE AT ALCOHOLICS ANONYMOUS (AA) OR OTHER ORGANIZED OUTPATIENT ALCOHOL RECOVERY PROGRAM.

E. AFTERCARE INTERVALS. THE MEMBER MUST VISIT THE FOLLOWING PROFESSIONALS AND ORGANIZATIONS, AT A MINIMUM, AT THE INTERVALS SPECIFIED:

1. FLIGHT SURGEON. MONTHLY FOR THE FIRST 12 MONTHS, THEN EVERY 3 MONTHS FOR THE REMAINING 2 YEARS.
2. DAPA/SACO. MONTHLY FOR THE ENTIRE 3 YEARS WITH DOCUMENTATION OF AA ATTENDANCE.
3. AA. ATTEND AT LEAST 3 TIMES PER WEEK FOR THE FIRST 12 MONTHS OUT OF TREATMENT, THEN NO LESS THAN 4 TIMES PER MONTH FOR THE REMAINDER OF THE DOCUMENTED RECOVERY PROGRAM. EXCEPTIONS TO THIS RECOVERY PROGRAM SCHEDULE FOR OPERATIONAL NECESSITY MUST RECEIVE COMMAND ENDORSEMENT.

F. ALL PERSONNEL WILL BE GIVEN A SERIES OF PHYSICAL EXAMINATIONS SPECIFIED TO PROVIDE ADDITIONAL MONITORING OF THE RECOVERY PROCESS. FORWARD ALL PHYSICALS TO BUMED (MED-236) LOCATED AT THE NAVAL OPERATION MEDICINE INSTITUTE (NAVOPMEDINST), NAVAL AIR STATION, PENSACOLA, FL 32508-1047. THESE EXAMINATIONS MUST INCLUDE A COMPLETE FLIGHT PHYSICAL (SF 88 AND 93 OR NAVMED 6120/2 AS APPROPRIATE) AS WELL AS THE FOLLOWING INFORMATION:

1. FLIGHT SURGEON'S NARRATIVE ASSESSMENT OF THE MEMBER'S RECOVERY SPECIFICALLY ADDRESSING: WORK PERFORMANCE, PEER RELATIONSHIPS, FAMILY AND MARITAL RELATIONSHIPS, PSYCHOSOCIAL STRESSORS AND ATTITUDE TOWARDS RECOVERY, ABSTINENCE AND AA ATTENDANCE. A MENTAL STATUS EXAMINATION SHOULD BE PERFORMED WITH REFERRAL TO NAVOPMEDINST FOR SPECIALIZED NEUROPSYCHOLOGICAL TESTING IF THERE ARE ANY QUESTIONS OF COGNITIVE IMPAIRMENT.
2. COPY OF LEVEL II OR LEVEL III TREATMENT SUMMARY (FIRST TIME ONLY).
3. FLIGHT SURGEON'S AND DAPA'S/SACO'S STATEMENTS TO DOCUMENT AFTERCARE, INCLUDING AA ATTENDANCE. (AA ATTENDANCE IS USUALLY VERIFIED BY SIGNATURE CARD AND RECORDED BY COMMAND DAPA/SACO.)
4. PSYCHIATRIC EVALUATION BY A PRIVILEGED PSYCHIATRIST OR CLINICAL PSYCHOLOGIST AT INITIAL WAIVER REQUEST, THEN ANNUALLY WHILE IN AFTERCARE.
5. INTERNAL MEDICINE EVALUATION AT INITIAL WAIVER REQUEST IF MEDICALLY INDICATED.

G. INTERVALS FOR PERFORMANCE OF FLIGHT PHYSICALS.

1. UPON DIAGNOSIS OF ALCOHOL DEPENDENCE OR ABUSE BY A FLIGHT SURGEON, OTHER MEDICAL OFFICER, OR CLINICAL PSYCHOLOGIST (A GROUNDING PE), PER REFERENCE E.
2. UPON INITIAL WAIVER REQUEST FOR AVIATION DUTY. MEMBER'S REQUEST LETTER MUST INCLUDE ACKNOWLEDGEMENT OF THE SPECIFIC REQUIREMENTS AND PROVISIONS OF THIS INSTRUCTION.
3. A COMPLETE PE MUST BE SUBMITTED ANNUALLY FOR CONTINUANCE OF WAIVER.

4. UPON RECOMMENDATION OF RETURN TO SERVICE GROUP I, SERVICE GROUP II, OR SERVICE GROUP III (CLASS I PERSONNEL).

5. UPON RECOMMENDATION OF RETURN TO NAVAL FLIGHT OFFICER, AIRCREW, HYPOBARIC INSIDE OBSERVER (CLASS II) AIR TRAFFIC CONTROLLER, OR UNMANNED AERIAL VEHICLE (CLASS III) OR INSTRUCTOR DUTIES.

6. UPON SUBSEQUENT RESTRICTION OF SPECIAL DUTY ASSIGNMENT FOR ANY REASON.

H. RETURN TO FLIGHT STATUS OR AVIATION RELATED DUTIES FOR ALL PERSONNEL:

1. NORMALLY AFTER 90 DAYS OF DEMONSTRATED RECOVERY AND MEETING THE CRITERIA IN PARAGRAPHS 6(D) AND (E). IN CASES OF CONTINUED PERSONAL TURMOIL, EMOTIONAL INSTABILITY, OR POOR ADHERENCE TO RECOVERY PROGRAM, THE FLIGHT SURGEON MAY WISH TO EXTEND THE OBSERVATION TIME AS LONG AS 12 MONTHS.

2. IN NO CASE SOONER THAN 30 DAYS AFTER SATISFACTORY COMPLETION OF THE APPROPRIATE TREATMENT PROGRAM FOR CLASS II AND III PERSONNEL.

3. THOSE DIAGNOSED AS ALCOHOL DEPENDENT AND ALL CLASS I AVIATION PERSONNEL WILL NORMALLY BE RETURNED TO AVIATION DUTIES AFTER AT LEAST 3 MONTHS OF DEMONSTRATED RECOVERY AND MEETING THE CRITERIA IN PARAGRAPHS 5(D) AND (E). IN CASES OF CONTINUED PERSONAL TURMOIL, EMOTIONAL INSTABILITY, OR POOR ADHERENCE TO RECOVERY PROGRAM, THE FLIGHT SURGEON MAY WISH TO EXTEND THE OBSERVATION TIME AS LONG AS 12 MONTHS. THE 30 DAY OPTION SHOULD ONLY BE USED IN THOSE CASES WITH MINIMUM RISK FACTORS, MINIMAL FAMILY OR PERSONAL TURMOIL, AND UNQUALIFIED PARTICIPATION IN TREATMENT AND RECOVERY.

I. SUBMIT INITIAL WAIVER REQUESTS AND FLIGHT PHYSICAL WITH COMMANDING OFFICER'S ENDORSEMENTS AND SPECIFIED CONSULTATIONS AND DOCUMENTATION TO MED 236 (NOMI CODE 42) FOR REVIEW.

J. IN LINE WITH CURRENT FAA AND NAVY AND MARINE CORPS POLICY, DISULFIRAM (ANTABUSE) THERAPY IS CONSIDERED TO BE DISQUALIFYING FOR DUTY INVOLVING FLIGHT OPERATIONS FOR ALL PERSONNEL WHO ARE INVOLVED IN THE CONDUCT AND SAFETY OF FLIGHT. A MINIMUM OF 14 DAYS SHOULD ELAPSE AFTER CESSATION OF DISULFIRAM BEFORE RESUMING FLYING DUTIES.

6. NONCOMPLIANCE. CONTINUED DENIAL OF AN ALCOHOL PROBLEM AND FAILURE TO ABSTAIN FROM ALCOHOL FOLLOWING TREATMENT IS UNACCEPTABLE FOR CONTINUED AVIATION STATUS IN ANY CAPACITY AND REQUIRES SUBMISSION OF SF 88 AND SF 93 TO BUMED 236. THE DISEASE CONCEPT OF ALCOHOLISM, PLUS POTENTIAL SAFETY CONSIDERATIONS, DOES NOT PERMIT A TRIAL OF SOCIAL DRINKING FOR AN INDIVIDUAL WITH A DIAGNOSIS OF ALCOHOL DEPENDENCE OR ABUSE. FAILURE TO ABSTAIN FROM ALCOHOL REQUIRES A RECOMMENDATION OF REVOCATION OF WAIVER FOR FLIGHT STATUS. FULL DOCUMENTATION FOR SUCH RECOMMENDATION MUST BE PROVIDED WITH ENDORSEMENT BY THE INDIVIDUAL'S COMMANDING OFFICER. FAILURE TO SUBMIT AFTERCARE DOCUMENTATION WILL RESULT IN REVOCATION OF WAIVER.

7. FORMS.

A. SF 88 (10/75), REPORT OF MEDICAL EXAMINATION, NSN 7540-00-634-4038, AND SF 93 (10/74), REPORT OF MEDICAL HISTORY, NSN 7540-00-181-8368, ARE AVAILABLE FROM FEDERAL SUPPLY SYSTEM THROUGH NORMAL SUPPLY PROCUREMENT PROCEDURES.

B. NAVMED 6120/2 (11-79), OFFICER PHYSICAL EXAMINATION QUESTIONNAIRE, S/N 0105-LF-208-3071, IS AVAILABLE FROM THE NAVY SUPPLY SYSTEM

M-T-V

U N C L A S S I F I E D

261300Z JUN 97

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AND MAY BE REQUISITIONED PER NAVSUP P-2002D.//

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U N C L A S S I F I E D

Pg 5

Effects on Patients of Health Professional's Attitudes

The behavior that results from negatively based professional attitudes about alcoholism and alcoholics will result in a more serious set of consequences for both the patient and the care provider than those mentioned for the general public.

Because the alcoholic patient is perceived as not legitimately ill, he or she will frequently be denied access to the health delivery system, i.e., "We don't admit alcoholics here." If the manifestations of illness are reflected in serious medical or psychiatric sequelae, the patient may then receive professional care for his or her presenting symptoms (burns, trauma, gastritis, depression, etc.) but not receive the appropriate care for the underlying illness of alcoholism.

Denial The patient's denial, which is part of his or her illness, is frequently joined by the denial of the professional staff, resulting in a "conspiracy of silence" in which neither patient nor care provider discusses or acknowledges what is known to both. This avoidance behavior contributes to the patient's discomfort and guilt and to the health professional's guilt and inadequacy. The health professional's denial also serves to further reinforce the patient's denial. Thus, one of the elements of this disease that causes the most anger among professionals--denial (if he won't admit that he's an alcoholic, then he doesn't really want help, and I can't give him any)--is unwittingly perpetuated when the professional uses denial also. This process typically takes this form: "My drinking's not so bad. If I really had a problem, the nurses and doctors would say something about it. Since they haven't that must mean I don't have a problem. I can't be an alcoholic because I'm here getting help for my ulcer, and that's all!"

The alcoholic patient, whose self-esteem is already damaged, fears that the disclosure of his or her alcohol abuse will further alienate others and increase feelings of rejection and isolation. Conversely, most alcoholic people, despite their denial, are desperately in need of someone with whom to share these feelings of rejection, isolation, and loss of control, someone who will not judge or shame them. Health professionals are conceptualized by most people as care givers; knowledgeable and skilled professionals, sought out by people when they are ill, hurt, in trouble, or in emotional trouble. When nurses, physicians, community health workers, psychologists, and others that treat the alcoholic patient with disgust, hostility, punitiveness, or even a subtle ambivalence, this sensitive patient will have his or her sense of worthlessness reinforced. For example, the patient might be feeling: "I must be no good to drink the way I do; I'm weak and worthless. The doctors and nurses here are disgusted with me, I can tell. I'm taking too much of their time, and they have given up hope on me. It must be true then--I am no good, and I'll never get any better." If the patient has little hope of recovery and health professionals reinforce this notion, the chances are the patient will live up to our expectations and not recover. The revolving door syndrome of repeated relapses and associated health care problems is thus perpetuated in part by health professionals.

Avoidance The feelings of frustration and inadequacy that care providers experience in attempting to treat alcoholic patients will result in avoidance of these patients when possible. When directly confronted with evidence that the patient's alcohol abuse is causing an acute or chronic health care problem, physician's and nurses will frequently "treat" the alcohol abuse with a cursory warning: "You had better stop drinking, it's killing you." Too often the patient is not appropriately treated or even referred to treatment resources; yet the same health professionals are surprised and disappointed when the patient reappears again ill and "still" abusing alcohol.

The avoidance and subterfuge that surrounds the care of the alcoholic patient can result in delay or nonprovision of lifesaving treatment. For example, a physician who has knowledge of a patient's alcoholism may admit the patient to the hospital under the diagnosis of "gastritis." When the patient has a grand mal seizure and delirium tremens 2

days later, the nursing staff and the residents are not prepared and a life-threatening, medical crisis ensues. The staff are angry and while it is really the admitting physician who is the object of their anger, it is far easier and safer to project that anger into the patient who is giving them "a rough time." This kind of cover-up is a disservice to both the patient and the staff.

The attitude held by many health professionals that the alcoholic must "hit bottom" before he or she can be treated can also delay appropriate treatment. The patient does not have to lose everything--family, job home, self-esteem, and health-- before help can be made available and accepted by the patient.

The professional's discomfort and ambivalence about alcoholism can interfere with motivation in attempting to provide treatment. And again, projective behavior in which the lack of motivation is attributed to the patient and serves as a rationalization for not offering treatment may be used. The patient is thus made responsible for initiating his or her own treatment. This is unfair; we do not place the same responsibilities on other chronically ill patients.

Another behavioral result of negative and moralistic attitudes is the loss of early treatment opportunities. Generally, the earlier a disease is treated, the better the prognosis will be; this holds true for alcoholism. Health care professionals who stereotype the alcoholic person as a weak-willed, aimless, homeless, derelict will fail to recognize the affluent, well-dressed, married, working individual in the early stages of alcoholism. The patient's prognosis is far worse by the time symptoms coincide with the health professional's stereotypical conception.

Negative attitudes frequently result in educational and clinical programs for health professionals that limit the amount of contact and experience students could obtain in working with alcoholic patients and their families. The educational vacuum is thus maintained, as are opportunities for changing negative attitudes through knowledge and experience.

Health professionals are surrounded by an atmosphere which discourages positive attitudes and reinforces negative ones. For example, the lack of appropriate insurance coverage in many places serves to reinforce the notion that alcoholism is not a legitimate disease. The truth is that insurance companies, like the population in general, are unenlightened. Insurance companies that do provide coverage for detoxification, rehabilitation, and general hospital services recognize that the treatment of alcoholism saves money in the long run.

Additionally, the problem of derived stigma (negative conceptions of those who work with or try to help alcoholics), discourages many professionals from adopting more positive attitudes. They fear that, like the alcoholic, they may be perceived by their peers as unacceptable and ultimately be rejected.

FOSTERING HELPFUL ATTITUDES AND MINIMIZING UNHELPFUL ONES

The health professional who reflects a positive, accepting, and knowledgeable attitude in the treatment of alcoholism can expect a more cooperative and hopeful patient. When the alcoholic patient is treated with respect and compassion, the likelihood is great that denial will decrease and treatment alternatives can, at the very least, be explored. The community health nurse who has nonjudgemental attitudes and appropriate understanding and expectations of the alcoholic patient is not as likely to take the patient's relapses as indications of her own professional inadequacy, and thus avoids the frustration, anger, and avoidance of her colleagues experience. The health professional with a more positive attitude feels less guilt and also blames the patient less. If the practitioner truly accepts the disease model of alcoholism, emotionally as well as rationally, and reflects

this in dealing with patients, then the patients can begin to regain their sense of self-esteem, worth, and dignity. The possibility of recovery becomes more realistic and the patients and staff will invest more in treatment opportunities.

What are Helpful Attitudes?

Helpful or positive attitudes have been mentioned briefly in previous sections. As a model toward which to work in shaping their own attitudes health professionals can consider these attitudes towards drinking, alcoholism, and alcoholic patients.

Drinking alcohol has no moral implication attached to it; those who do drink alcohol are not necessarily bad or good.

Drunkenness is neither comical nor disgusting, but rather a serious effect of an overdose of a drug.

Alcoholism is a disease; although complex and not completely understood, it is a disease as legitimate as any other.

Health care providers have professional responsibilities in treating patients and families who are the victims of alcoholism to the best of their skill, knowledge, and capabilities.

What most people ask about Alcoholics Anonymous

Anonymous

Editor's note: Alcoholics Anonymous has about 1.5 million members in 76,000 groups in 114 countries. Following are excerpts from the pamphlet "A Newcomer Asks..." published by Alcoholics Anonymous to answer the questions most frequently asked by people approaching A.A. for the first time. The excerpts are published with permission of A.A. World Services.

Am I an alcoholic?

If you repeatedly drink more than you intend or want to, if you get into trouble, or if you have memory lapses when you drink you may be an alcoholic. Only you can decide. No one in A.A. will tell you whether you are or not.

The 12 Steps

The 12 Steps of the Alcoholics Anonymous program were drawn up by the recovering alcoholics who founded the fellowship more than a half century ago. They are the essence of the A.A. program. Other organizations dealing with addictive behavior have adapted them for their own use with permission of A.A.

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(The 12 Steps are reprinted with permission of Alcoholics Anonymous Word Service Inc. Permission to reprint this material does not mean that A.A. has reviewed the contents of this section nor that A.A. agrees with the views expressed herein. A.A. is a program of recovery from alcoholism. Use of the steps in connection with programs which are patterned after A.A. but which address other problems does not imply otherwise.)

What can I do if I am worried about my drinking?

Seek help. Alcoholics Anonymous can help.

What is Alcoholics Anonymous?

We are a fellowship of men and women who have lost the ability to control our drinking and have found ourselves in various kinds of trouble as a result of drinking. We attempt - most of us successfully - to create a satisfying way of life without alcohol. For this we find we need help and support of other alcoholics in A.A.

If I go to an A.A. meeting, does that commit me to anything?

No. A.A. does not keep membership files, or attendance records. You do not have to reveal anything about yourself. No one will bother you if you don't want to come.

What happens if I meet people I know?

They will be there for the same reason you are there. They will not disclose your identity to outsiders. At A.A. you retain as much anonymity as you wish. That is one of the reasons we call ourselves Alcoholics Anonymous.

What happens in an A.A. meeting?

An A.A. meeting may take one of several forms, but at any meeting you will find alcoholics talking about what drinking did to their lives and personalities, what actions they took to help themselves, and how they are living their lives today.

How can this help me with my drinking problem?

We in A.A. know what it is like to be addicted to alcohol, and to be unable to keep promises made to others and ourselves that we will stop drinking. We are not professional therapists. Our only qualification for helping others to recover from alcoholism is that we have stopped drinking ourselves, but problem drinkers coming to us know that recovery is possible because they see people who have done it.

Why do A.A.'s keep going to meetings after they are cured?

We in A.A. believe there is no such thing a cure for alcoholism. We can never return to normal drinking, and our ability to stay away from alcohol depends on maintaining our physical, mental and spiritual health. This we can achieve by going to meetings regularly and putting into practice what we learn there. In addition we find that it helps us to stay sober if we help other alcoholics.

How do I join A.A.?

You are an A.A. member if and when you say so. The only requirement for an A.A. membership is a desire to stop drinking, and many of us were not very wholehearted about that when we first approached A.A.

How much does an A.A. membership cost?

There are no dues or fees for an A.A. membership. An A.A. group will usually have a collection during the meeting to cover expenses, such as rent, coffee, ect., and to this all members are free to contribute as much or as little as they wish.

Is A.A. a religious organization?

No. Nor is it allied with any religious organization.

There's a lot of talk about God, though, isn't there?

The majority of A.A. members believe that we have found the solution to our drinking problem not through individual willpower, but through a power greater than ourselves. However, everyone defines this power as he or she wishes. Many people call it God, others think it is the A.A. group, still others don't believe it at all. There is room in A.A. for people of all shades of belief and nonbelief.

Can I bring my family to an A.A. meeting?

Family members or close friends are welcome at "open" A.A. meetings. Discuss this with your local contact.

What advice do you give to new members?

In our experience those who recover in A.A. are those who:

- (a) Stay away from the first drink
- (b) Attend A.A. meetings regularly
- (c) Seek out the people in A.A. who have successfully stayed sober for some time
- (d) Try to put into practice the A.A. program of recovery

CHAPTER FOUR

ADJUSTMENT DISORDERS AND "V" CODES

The rest of the story



TERMINAL OBJECTIVE

- Upon completion of this period of instruction, the SFS Extraordinaire will render an accurate DSM-IV diagnosis when presented with symptoms characteristic of an adjustment disorder or "v" code condition



ENABLING OBJECTIVES

- State the DSM-IV criteria for an adjustment disorder and symptom subtypes
- Describe clinical presentations consistent with a "v" code diagnosis
- Differentiate between adjustment, mood and anxiety disorders
- Discuss aeromedical disposition issues pertaining to adjustment disorder/ "v" code diagnoses

ADJUSTMENT DISORDERS

- Maladaptive reaction within three months of onset of stressor/s
- Distress in excess of normal reaction
- Not manifestation of personality disorder
- Symptoms resolve within 6 months of termination of stressor
- Acute versus Chronic



CODED SYMPTOM SUBTYPES

- With Depressed Mood
- With Anxiety
- With Anxiety and Depressed Mood
- With Disturbance of Conduct
- With Mixed Disturbance of Emotions and Conduct
- Unspecified

DIFFERENTIAL DIAGNOSES

- Residual category
- "V" Codes--severity of reaction to stressor
- PTSD--severity of stressor /specific sx
- Mood /Anxiety disorders--severity of sx
- Personality disorder--quality of sx
- Bereavement
- Bad day at work

NO!!! NO!!! NO!!!

AXIS I: Adjustment Disorder
AXIS II: Personality Disorder

“Because Personality Disorders are frequently exacerbated by stress, the additional diagnosis of Adjustment Disorder is usually not made.”
DSM-IV pg625

TREATMENT

- Supportive therapy
- Brief, goal-directed psychotherapy
- Most recover with or without therapy
- Therapy could hasten recovery
- 50% of patients treated resolve in 1 month
- Medication for target symptom



Aeromedical Disposition

- NPQ during treatment
- No waiver required



“V” CODES

- Other conditions that may be a focus of treatment
- Problems in living
- Not a mental disorder
- List on Axis I



FOCUS OF TREATMENT

- Relational problems
- Problems related to abuse or neglect
- Additional conditions

Consider “V” Codes When:

- Problem is the focus of tx with no mental disorder
- Pt has a mental disorder but it is unrelated to the problem
- Pt has a mental disorder related to the problem which is sufficiently severe to warrant special clinical attention

RELATIONAL PROBLEMS

- Relational Problem Related to a Mental Disorder or General Medical Condition
- Parent-Child Relational Problem
- Partner Relational Problem
- Sibling Relational Problem
- Relational Problem N.O.S.



PROBLEMS RELATED TO ABUSE OR NEGLECT

- Physical Abuse of Child
- Sexual Abuse of Child
- Neglect of Child
- Physical Abuse of Adult
- Sexual Abuse of Adult

ADDITIONAL CONDITIONS

- Noncompliance With Treatment
- Malingering
- Adult Antisocial Behavior
- Child or Adolescent Antisocial Behavior
- Borderline Intellectual Functioning
- Age-Related Cognitive Decline
- Bereavement

OTHER CONDITIONS CONT'D

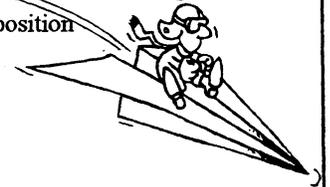
- Occupational Problem
- Identity Problem
- Religious or Spiritual Problem
- Acculturation Problem
- Phase of Life Problem

EXAMPLES

- AXIS I: V62.2 Occupational Problem
AXIS II: Narcissistic personality traits
- AXIS I: V62.82 Bereavement
AXIS II: 301.9 Personality Disorder NOS
- AXIS I: 309.9 Adjustment DO
AXIS II: V71.09 No Diagnosis

SUMMARY

- Diagnosis and treatment of Adjustment Disorders and "V" Codes
- Considerations for differential diagnoses
- Aeromedical disposition



CHAPTER FIVE



Psychotic and Anxiety Disorders

CDR Mark Mittauer

Outline

- ✦ Discuss diagnostic criteria for the major psychotic and anxiety disorders
- ✦ Discuss the aeromedical and general duty dispositions
- ✦ Discuss the treatment

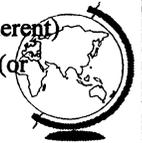


Psychotic Disorders



General

- ✦ Psychosis: a gross impairment in reality testing
- ✦ Symptoms:
 - hallucinations (5 senses)
 - delusions (fixed, false belief)
 - disorganized speech (ex. incoherent)
 - grossly disorganized behavior (or catatonic)



General (cont.)

- ✦ Diagnosis usually NPQ/unfit - and results in a Medical Board discharge
- ✦ Three exceptions to the above rule!
- ✦ Potentially very dangerous (suicide and violent behavior towards others)
- ✦ DO NOT MISS ORGANIC CAUSES! (potentially lethal)



Classification

- ✦ Psychotic Disorder Due to a General Medical Condition
- ✦ Substance-Induced Psychotic Disorder
- ✦ Delirium
- ✦ Dementia
- ✦ Schizophrenia
- ✦ Schizophreniform Disorder
- ✦ Brief Psychotic Disorder



(Cont.)

- ✦ Schizoaffective Disorder
- ✦ Delusional Disorder
- ✦ Atypical Psychotic Disorders
- ✦ Culture-Bound Psychotic Syndromes
- ✦ Psychotic Disorder NOS



Psychotic Disorder Due to a General Medical Condition

- ✦ Diagnosis: hallucinations or delusions
organic cause
- ✦ CNS:
 - epilepsy (TLE) brain trauma
 - neoplasm
- ✦ Infections:
 - viral/bacterial (meningitis, encephalitis)
 - HIV
 - neurosyphilis



Other Organic Causes

- ✦ carbon monoxide poisoning
- ✦ heavy metals poisoning
- ✦ SLE (lupus)
- ✦ Wilson's disease
- ✦ NPH (normal pressure hydrocephalus)
 - ataxia, incontinence



(Cont.)

- ✦ Aeromedical disposition:
 - NPQ while patient is psychotic
 - unfit while patient is psychotic
 - reverts to PQ when symptoms resolved and the underlying "organic factors are identified and deemed unlikely to recur"
 - no waiver needed
- ✦ Treatment: underlying condition;
neuroleptic/benzodiazepine for agitation



Substance-Induced Psychotic Disorder

- ✦ Diagnosis: hallucinations or delusions
caused by medication use
(within one month of intoxication or withdrawal)
- ✦ Drugs:
 - hallucinogens (LSD, PCP, mescaline)
 - stimulants (cocaine, amphetam., ephedrine)
 - other - steroids, antihistamines, thyroxin,
disulfiram, anticholinergics (atropine)



(Cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit while patient is psychotic
 - reverts to PQ/fit when resolved (unless the cause was alcohol or illicit drugs)
 - no waiver needed
- ✦ Treatment:
 - stop the drug!
 - neuroleptic/benzodiazepine for agitation



Schizophrenia - Diagnosis

- ✦ Two or more “characteristic” symptoms:
 - delusions
 - hallucinations
 - disorganized speech (ex. incoherent)
 - grossly disorganized or catatonic behavior
 - negative symptoms (flat affect, social withdrawal, anhedonia, apathy)
- ✦ Functional deterioration (work, social)
- ✦ Duration six or more months (1 mo. active)



Schizophrenia - Characteristics

- ✦ 1% lifetime prevalence
- ✦ median age of onset - 15 to 25 (men)
- ✦ five subtypes (ex., paranoid, catatonic, disorganized)
- ✦ 10 - 15% suicide (50% attempt)
- ✦ potential for violence



Schizophrenia (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - medical board discharge
 - no waiver
- ✦ Treatment:
 - antipsychotics (haloperidol, risperidone, clozapine, olanzapine, sertindole)



Schizophreniform Disorder

- ✦ Diagnosis:
 - same symptoms as for schizophrenia
 - symptoms last for more than one month but less than six months
- ✦ Characteristics:
 - abrupt onset of symptoms
 - precipitating stressor often present
 - better prognosis than for schizophrenia



Schizophreniform Disorder (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - medical board discharge
 - no waiver
- ✦ Treatment: same as for schizophrenia



Brief Psychotic Disorder (“Brief Reactive Psychosis”)

- ✦ Diagnosis:
 - psychotic symptoms (often fewer and less severe than for schizophrenia)
 - symptoms resolve within one month
- ✦ May be caused by a significant stressor (ex. combat, natural disaster)
- ✦ abrupt onset of symptoms
- ✦ good prognosis (50% to 80% have no future psychiatric illness)



Brief Psychotic Disorder (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit (limited duty medical board)
- ✦ Waiver possible if:
 - significant precipitating stressor
 - good prognostic features (ex. abrupt onset, brief duration, mood symptoms)
 - one year after all symptoms resolved without recurrence, and taking no psychotropic medications



Schizoaffective Disorder

- ✦ Diagnosis:
 - symptoms of both schizophrenia and a mood disorder (ex. depression, mania)
 - at least two weeks of psychotic symptoms without mood symptoms
- ✦ Characteristics:
 - better prognosis than schizophrenia
 - worse prognosis than mood disorder



Schizoaffective Disorder (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - medical board discharge
 - no waiver
- ✦ Treatment:
 - antidepressant (SSRI) or mood stabilizer (lithium, valproic acid, carbamazepine)
 - neuroleptic only if essential; short term



Delusional Disorder

- ✦ Diagnosis:
 - nonbizarre delusion for at least 1 month
 - functioning not greatly impaired
- ✦ Types:
 - erotomanic
 - grandiose
 - jealous
 - persecutory
 - somatic
 - mixed
- ✦ Less common than schizophrenia
- ✦ May begin after a specific stressor



Delusional Disorder (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - medical board discharge
- ✦ Treatment:
 - neuroleptic (haloperidol, risperidone, pimozide)



Atypical Psychotic Disorders

- ✦ Example: Shared Psychotic Disorder (folie a deux)
- ✦ Aeromedical disposition:
 - NPQ/unfit
 - medical board discharge
 - no waiver



Culture-Bound Psychotic Syndromes

- ♦ Many examples that are culture specific
- ♦ Example: Koro (disappearing genitals or breasts)



Psychotic Disorder, NOS (Not Otherwise Specified)

- ♦ Diagnosis: psychotic symptoms that do not meet criteria for any specific psychotic d.o.
- ♦ Examples:
 - Postpartum psychosis (probably a bipolar or depressive disorder)
 - Capgras's syndrome (familiar people are replaced by impostors)
 - Lycanthropy (werewolf delusion)
 - Autoscopical psychosis
- ♦ Disposition: NPQ/unfit/no waiver/board



Summary

- ♦ Disposition for most psychotic disorders is NPQ/unfit - with no waiver possible
- ♦ Exceptions:
 - Psychotic Disorder Due to a General Medical Condition
 - Substance-Induced Psychotic Disorder
 - Brief Psychotic Disorder (with marked precipitating stressor and good prognostic features)



Anxiety Disorders



Definitions

- ♦ normal anxiety = apprehension + autonomic symptoms
- ♦ pathological anxiety = inappropriate anxiety
- ♦ fear = dread due to a known threat



General Characteristics

- ♦ common
- ♦ lifetime prevalence: 30.5% male
19.2% female
- ♦ comorbidity common (ex: depression, substance abuse, several anxiety disorders)
- ♦ significant suicide risk
- ♦ genetic predisposition (especially panic disorder)



DSM-IV Classification

- ✦ Anxiety Disorder Due to a General Medical Condition
- ✦ Substance-Induced Anxiety Disorder
- ✦ Panic Disorder (+/- Agoraphobia)
- ✦ Agoraphobia
- ✦ Specific Phobia
- ✦ Social Phobia
- ✦ Obsessive-Compulsive Disorder



Classification (cont.)

- ✦ Generalized Anxiety Disorder
- ✦ Posttraumatic Stress Disorder
- ✦ Acute Stress Disorder
- ✦ Anxiety Disorder, NOS



Anxiety Disorder Due to a General Medical Condition

- ✦ Most commonly presents with panic attacks
- ✦ Neurological:
 - CNS trauma - migraine
 - subarachnoid hemor. - epilepsy (TLE)
- ✦ Endocrine:
 - thyroid dysfunc. - hypoglycemia
 - pheochromocytoma - diabetes
- ✦ Pulmonary: asthma



Organic Causes (cont.)

- ✦ Hypoxia:
 - anemia - cardiac arrhythmia - MI
- ✦ Other:
 - heavy metal poisoning - mononucleosis
 - electrolyte imbalance
- ✦ Treatment: "fix" the underlying condition



Substance-Induced Anxiety Disorder

- ✦ Anxiety occurs during, or within one month of, substance intoxication or withdrawal
- ✦ alcohol
- ✦ stimulants: amphetamine, cocaine, caffeine
- ✦ serotonergics: LSD, MDMA, PCP
- ✦ inhalants: solvents, glue, gasoline, paint
- ✦ prescription: antidepressants
benzodiazepines
PCN, sulfonamides, ASA



Panic Disorder (with or without Agoraphobia)

- ✦ Panic attack = discrete period of intense fear or discomfort + at least 4 (of 13) symptoms that start abruptly and peak within 10 min.
- ✦ Diagnosis:
 - recurrent, unexpected panic attacks
 - at least 1 month of concern about having another attack, the result of an attack (MI, CVA), or change in behavior due to attack
 - not caused by organic or specific stressor



Agoraphobia

- ✦ anxiety about being in a situation where, *if one has a panic attack*, escape would be hard or help would not be available
- ✦ can diagnose alone or with Panic Disorder



Panic Disorder (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - limited duty or medical board discharge
 - waiver possible 1 year after condition resolved, off meds, treatment ended
- ✦ Treatment:
 - medical work-up
 - behavioral therapy
 - drugs: antidepressant (SSRI, TCA, MAOI)
 - brief benzodiazepine (Xanax, Klonopin)



Social Phobia

- ✦ Diagnosis:
 - fear of scrutiny or exposure to strangers
 - patient fears showing anxiety or acting in an embarrassing way
 - interferes with social or job functioning
- ✦ Aeromedical disposition:
 - PQ/fit generally
 - NPQ if mission execution (briefing) or flight safety compromised



Social Phobia - Treatment

- ✦ cognitive-behavioral therapy
- ✦ exposure therapy (desensitization)
- ✦ b-blocker (propranolol, atenolol) - especially for performance anxiety
- ✦ benzodiazepine (alprazolam, clonazepam)
- ✦ MAOI (Nardil)
- ✦ SSRI



Specific Phobia

- ✦ marked, unreasonable fear of specific stimulus or situation
- ✦ stimulus avoided
- ✦ interferes with functioning
- ✦ most common (to least common): animals, storms, heights, illness, injury, death



Specific Phobia (cont.)

- ✦ Aeromedical disposition:
 - PQ/fit generally
 - NPQ if mission execution or flight safety impacted (i.e., no wear mask)
 - waiver possible 1 year after condition resolved, off meds, not in treatment
- ✦ Treatment: exposure therapy (desensitization), cognitive-behavioral therapy



Obsessive-Compulsive Disorder (OCD)

- ✦ either obsessions or compulsions
- ✦ obsession: intrusive thoughts or impulses that cause anxiety and are ego-alien (dislike)
- ✦ compulsion: repetitive behaviors or mental acts that one feels compelled to do to neutralize the obsession
- ✦ o. and c. - cause marked distress
 - time-consuming (1+ hours/day)
 - interfere with functioning



OCD Presentation (cont.)

- ✦ Most common to least common:

<u>obsession</u>	<u>compulsion</u>
contamination	washing, cleaning
doubt	checking
repetitive thought	mental rituals
symmetry/precision	slowness



OCD (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - limited duty or medical board
 - waiver possible 1 year after condition resolved, off meds, out of treatment
- ✦ Treatment:
 - behavioral therapy (exposure, response prevention)
 - meds: SSRI (fluvoxamine), clomipramine
 - heroic: ECT, psychosurgery



Posttraumatic Stress Disorder (PTSD) - Diagnosis

- ✦ symptoms present more than one month
- ✦ exposure to a traumatic event that caused intense fear, helplessness, or horror
- ✦ reexperience the event (flashbacks, nightmares, distress when reminded of event)
- ✦ avoidance/numbing (amnesia, intentional forgetting, detachment, anhedonia)
- ✦ hyperarousal (insomnia, irritable, hypervigilant, startles easily)



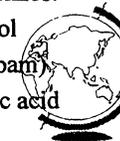
PTSD (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - limited duty or medical board discharge
 - waiver possible 1 year after condition resolved, off meds, out of treatment
- ✦ May see delayed onset (months to years after the traumatic event)



PTSD - Treatment is Symptom Focused

- ✦ psychotherapy (cognitive-behavioral)
- ✦ EMDR (Eye-Movement Desensitization and Reprocessing)
- ✦ depression: SSRI, TCA
- ✦ insomnia: zolpidem, trazodone, benzos.
- ✦ hyperarousal: clonidine, propranolol
- ✦ anxiety: benzodiazepine (clonazepam)
- ✦ impulsivity/mood lability: valproic acid



Acute Stress Disorder

- ✦ Like PTSD, except symptoms last less than one month and begin within one month of the traumatic event
- ✦ dissociation symptoms (numbing, dazed, derealization, depersonalization, amnesia)
- ✦ reexperience the trauma
- ✦ avoidance
- ✦ hyperarousal



Acute Stress Disorder (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - limited duty medical board
 - waiver possible 6 months after condition resolved, off meds, out of treatment
- ✦ Prevention: Critical Incident Stress Debrief (CISD) within 72 hours after a traumatic event



Generalized Anxiety Disorder (GAD)

- ✦ symptoms last at least six months
- ✦ excessive worry about several life circumstances
- ✦ autonomic arousal (irritable, tense, insomnia, etc.)
- ✦ symptoms interfere with functioning



GAD (cont.)

- ✦ Aeromedical disposition:
 - NPQ/unfit
 - limited duty or medial board discharge
 - waiver possible one year after condition resolved, off meds, out of treatment
- ✦ Treatment:
 - psychotherapy (cognitive-behavioral)
 - drugs: buspirone, benzodiazepin, SSRI



Summary

- ✦ Look for organic causes and treat
- ✦ All anxiety disorders can be waived one year after condition resolved, off meds, out of treatment
- ✦ Simple Phobia and Specific Phobia usually PQ
- ✦ All other anxiety disorder diagnoses are NPQ/unfit



Finis



CHAPTER SIX

Mood Disorders and Grief

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999

Terminal Objectives

At the completion of this lecture the student will understand:

1. The spectrum of mood disorders
2. Common aeromedical dispositions in mood disorders
3. Normal and abnormal grief
4. The flight surgeon's role

Enabling Objectives

- Discuss the diagnostic criteria for Major Depressive Disorder
- Describe the aeromedical and general disposition of the major mood disorders
- Provide an example of normal and abnormal grief
- Discuss the informal "grief" plans you will develop at your commands

MOOD DISORDERS

- Most common MAJOR psychiatric disturbance
- Rapid onset requires early recognition and intervention
- Operational impairment significant

MOOD DISORDERS

- Major Depressive Disorder
- Bipolar Disorder
- Dysthymia
- Cyclothymic Disorder
- Depressive Disorder NOS
- Substance-induced Mood Disorder
- Mood Disorder Due to a General Medical Condition

MAJOR DEPRESSION

- lifetime prevalence of 15%(25% in women) - 10% of primary care pts
- 50% have recurrence, often within 6 months
- treatable in 80% of patients
- 15% of depressed patients commit suicide

DSM-IV

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2 week period and represent a change from previous functioning; at least one of the symptoms is either (1) *depressed mood* or (2) *loss of interest or pleasure*

B-E: Other qualifiers. . . see p163 of your DSM-IV

Criteria for MD Episode (cont)

- Depressed mood (subjective or observation)
- Diminished interest or pleasure
- Weight loss or gain (5%/mo) or significant appetite change
- insomnia or hypersomnia
- psychomotor agitation or retardation
- fatigue or loss of energy
- feelings of excessive guilt or worthlessness
- diminished ability to think or concentrate
- recurrent thoughts of death, SI without plan, or suicide attempt

Pneumonic for MD:

SIG E CAPS

- Sleep disturbance
- Interest Waning
- Guilt
- Energy
- Concentration
- Appetite
- Psychomotor Retardation
- Suicidal Ideations/Behavior

ALWAYS ASK
ABOUT SUICIDE

Necessary Clinical Information

- Family history
- Past history of depression/mania
- Medical symptoms/history/meds
- Current stressors
- Level of functioning
- ETOH/drug use

Differential Diagnosis

- Substance abuse/dependence
- Stimulant withdrawal
- Hypothyroidism
- Medications
- Malignancy
- Zebras, etc...

A Caveat

The prevalence of mood disorders does not differ from race to race. **However**, clinicians tend to underdiagnose mood disorders and to overdiagnose schizophrenia in patients who have racial or cultural backgrounds different from their own. White psychiatrists, for example, tend to underdiagnose mood disorders in Blacks and Hispanics

Treatment of Depression

- Antidepressants (SSRIs/TCAs)
- Psychotherapy (Cognitive/behavioral, interpersonal, supportive, etc.)
- ECT (electricity can be good)
- (environmental manipulation - if improve quickly, think PDs)

Disposition of Depression

- NPQ and AA
 - Waiverable for a single episode without psychotic symptoms
 - 1 year off meds/symptoms-free
- Unfit and Suitable for General Duty
 - LIMDU Board

Bipolar Disorder

- Lifetime prevalence of 1% (about the same as for schizophrenia)
- Requires h/o a manic episode (abnormally elevated, expansive, or irritable mood lasting at least one week & causes marked impairment)
- **Manic symptoms:**
 - grandiosity
 - decreased need for sleep
 - rapid speech

Bipolar Disorder Manic Symptoms (cont.)

- racing thoughts (flight of ideas)
- distractibility
- increased goal-directed activity or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences
- (hypersexuality, excessive religiosity, increased spending may be seen - psychotic sx if remains untreated)

Bipolar Disorder Genetic Loading

- One parent bipolar - 25% risk
- Two parents bipolar - 50% risk
- Twin studies:
 - monozygotic: 33-90% (50% for MD)
 - dizygotic: 5-25%

Treatment of Bipolar Disorder

- Rapid Tranquilization as needed
 - (cocktail of 5mg haldol and 2mg ativan - po or IM)*
- Antipsychotics acutely*
- Lithium Carbonate
- Valproate and carbamazepine (the SSRIs of Bipolar D/O)

* physical restraint prior to chemical restraint

Disposition of Bipolar Disorder

- NPQ and AA - NO WAIVER
- Unfit and suitable for general duty-PEB

Other Mood Disorders

- Dysthymic Disorder ("dep neurosis")
- Cyclothymic Disorder ("mild bipolar")
- Depressive Disorder NOS
 - Recurrent Brief Depressive Disorder
 - Premenstrual Dysphoric Disorder
 - Postpartum Depression, Mild
- Disposition: NPQ and AA, Unfit and Suitable, LIMDU Board. Waiver possible after one year symptom-free, off meds, out of treatment

GRIEF REACTIONS

- Occurrence in the operational environment
- Normal reactions to loss
- Recognition

Stages of Grief

- Shock
- Preoccupation with deceased
- Resolution

Symptoms of Grief

- Somatic distress
- Preoccupation with the deceased
- Guilt
- Hostility
- Agitation

Complicating Factors

- Death circumstances
- Support
- Conflicts with the deceased
- Management of residual anger/guilt

Pathological Grief

- Extreme
- Absent
- Prolonged
- Distorted

Delayed Grief

- Suppression/denial
- Cultural restrictions
- Replacement of love object
- Anniversary reaction

Grief In Children

- Similar to adults
- Their ability to understand death depends on their ability to understand any abstract concept
- <5 - death is separation similar to sleep
- 5-10: developing sense of mortality
- By puberty can conceptualize death as universal, irreversible, and inevitable

Flight Surgeon's Role

- Availability
- Periodic visits
- Monitor medical status of survivor
- Refer if needed (chaplain, FSC first)

Flight Surgeon's Bag of Tricks

- Know your local resources and meet with them (chaplains, FSC, MHC)
- Read through and be comfortable with Chapter 30 of the Handbook - SPRINT & CISD - know local plan
- Have a variety of "bereavement plans"
- Ensure your CO understands the role of SPRINT interventions: dispel myths
- *Common sense and empathy*

Interpreting the Beck Depression Inventory (BDI)

The Beck Depression Inventory was developed by Dr. Aaron Beck in 1978 and is an invaluable adjunct for any clinician (primary care or mental health) to use to assess the severity of depression once it is diagnosed. It can also be used to detect depressive symptoms in clinic patients who do not present with overt symptoms of depression but may have a depression underlying their somatic or other symptoms. It is a very useful tool to monitor the course of depression during treatment. Please *do not* use the BDI as a substitute for the interview, which is your primary diagnostic modality.

<i>Total Score</i>	<i>Levels of Depression</i>
1-10	These ups and downs are considered normal.
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

CAVEAT!!! Item #9 is what we call a critical item. You **MUST** look at the score on this and address (and document) any evidence of suicidality in the patient. This is just like any other critical value the lab would report to you that indicates an emergency (platelet count of 20K, NA⁺ of 120, K⁺ level of 6.0, etc. etc.) [Wear's Axiom: **NEVER** order a test unless your diagnosis/treatment will, in some way, be affected by the outcome]

Also, be aware that anyone with secondary gain may endorse many symptoms (i.e. malingering) - use it only with selected patients, not as a general screening tool for all patients.

Beck Depression Inventory

In each group of sentences below, choose the *one* sentence that *best* describes how you are feeling **now** and circle the number in front of it.

- | | | | |
|-----|---|------|--|
| 0-1 | I do not feel sad | 0-8 | I don't feel I am any worse than anybody else |
| 1 | I feel sad | | |
| 2 | I am sad all the time and can't snap out of it | 1 | I am critical of myself for my weaknesses or mistakes |
| 3 | I am so sad or unhappy that I can't stand it | 2 | I blame myself all the time for my faults |
| 0-2 | I am not particularly discouraged about the future | 3 | I blame myself for everything bad that happens |
| 1 | I feel discouraged about the future | | |
| 2 | I feel I have nothing to look forward to | 0-9 | I don't have any thoughts of killing myself |
| 3 | I feel that the future is hopeless and that things cannot improve | 1 | I have thoughts of killing myself, but I would not carry them out |
| 0-3 | I do not feel like a failure | 2 | I would like to kill myself |
| 1 | I feel I have failed more than the average person | 3 | I would kill myself if I had the chance |
| 2 | As I look back on my life, all I can see are a lot of failures | | |
| 3 | I feel I am a complete failure as a person | 0-10 | I don't cry any more than usual |
| 0-4 | I get as much satisfaction out of things as I used to | 1 | I cry more now than I used to |
| 1 | I don't enjoy things the way I used to | 2 | I cry all the time now |
| 2 | I don't get real satisfaction out of anything anymore | 3 | I used to be able to cry, but now I can't cry even though I want to |
| 3 | I am dissatisfied or bored with everything | | |
| 0-5 | I don't feel particularly guilty | 0-11 | I am no more irritated now than I ever am |
| 1 | I feel guilty a good part of the time | 1 | I get annoyed or irritated more easily than I used to |
| 2 | I feel quite guilty most of the time | 2 | I feel irritated all the time now |
| 3 | I feel guilty all of the time | 3 | I don't get irritated at all by the things that used to irritate me |
| 0-6 | I don't feel I am being punished | | |
| 1 | I feel I may be punished | 0-12 | I have not lost interest in other people |
| 2 | I expect to be punished | 1 | I am less interested in other people than I used to be |
| 3 | I feel I am being punished | 2 | I have lost most of my interest in other people and have little feeling for them |
| 0-7 | I don't feel disappointed in myself | 3 | I have lost most of my interest in other people and don't care about them at all |
| 1 | I am disappointed in myself | | |
| 2 | I am disgusted with myself | 0-13 | I make decisions about as well as I ever could |
| 3 | I hate myself | 1 | I put off making decisions more than I used to |
| | | 2 | I have greater difficulty in making decisions than before |
| | | 3 | I can't make decisions at all anymore |

Beck Depression Inventory - page 2

- 0-14 I don't feel I look any worse than I used to
- 1 I am worried that I am looking old or unattractive
 - 2 I feel that there are permanent changes in my appearance that make me look unattractive
 - 3 I believe that I look ugly
- 0-15 I can work about as well as before
- 1 It takes an extra effort to get started at doing something
 - 2 I have to push myself very hard to do anything
 - 3 I can't do any work at all
- 0-16 I can sleep as well as usual
- 1 I don't sleep as well as I used to
 - 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
 - 3 I wake up several hours earlier than I used to and cannot get back to sleep
- 0-17 I don't get more tired than usual
- 1 I get tired more easily than I used to
 - 2 I get tired from doing almost anything
 - 3 I am too tired to do anything
- 0-18 My appetite is no worse than usual
- 1 My appetite is not as good as it used to be
 - 2 My appetite is much worse now
 - 3 I have no appetite at all anymore
- 0-19 I haven't lost much weight, if any, lately
- 1 I have lost more than 5 pounds (if any weight is lost through intentional diet or exercise disregard this question)
 - 2 I have lost more than 10 pounds
 - 3 I have lost more than 15 pounds
- 0-20 I am no more worried about my health than usual
- 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation
 - 2 I am very worried about physical problems and it's hard to think of much else
 - 3 I am so worried about my physical problems that I cannot think about anything else
- 0-21 I have not noticed any recent change in my interest in sex
- 1 I am less interested in sex than I used to be
 - 2 I am much less interested in sex now
 - 3 I have lost interest in sex completely

CHAPTER SEVEN

Intro to Psychotherapy

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999

Terminal Objectives

At the completion of this lecture the student will:

- Understand the definition of psychotherapy
- Establish a comfort level with doing supportive psychotherapy
- Understand the basic principles of cognitive therapy and how to apply them

Enabling Objectives

- Provide three characteristics of supportive psychotherapy
- Describe a situation appropriate for a flight surgeon to provide supportive psychotherapy
- State the basic premise of cognitive therapy
- Explain the term, "cognitive distortion"
- Discuss when cognitive therapy can be used

Supportive Psychotherapy

- offers the patient support by an authority figure during a period of illness, turmoil, or temporary decompensation
- also has the goal of restoring and strengthening the patient's defenses and integrating capacities (reality testing)

Supportive Psychotherapy

Uses a number of methods

- warm, friendly, strong leadership
- gratification of dependence needs (healthy to a degree)
- support in the ultimate development of legitimate independence
- help in the development of pleasurable sublimations (work, hobbies, school)
- adequate rest and diversion

Supportive Psychotherapy

(cont.)

- removal of excessive external strain if possible
- hospitalization if required
- medication when indicated
- guidance and advice in dealing with current issues

A large part of your job as a flight surgeon will be doing one or more of the above entities with your patients

Your role is that of a coach who provides objective feedback, options, and prognostic estimates based on data and experience

The most effective tool you have is a good therapeutic alliance

Psychotherapies

(Some examples of types)

- Psychodynamic Psychotherapy
- Hypnosis
- Biofeedback
- Behavioral
- Cognitive-Behavioral
- Group
- etc.

Cognitive Therapy

- An active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders (depression, anxiety, phobias, pain, etc.)
- a person's feelings are largely dictated by how he or she interprets situations; a switch from a negative to a positive (or neutral) interpretation of a situation will lessen the negative feeling

Cognitive Triad of Depression

- Negative self-percept that sees oneself as defective, inadequate, deprived, worthless, and undesirable
- A tendency to experience the world as a negative, demanding, and self-defeating place and to expect failure and punishment
- The expectation of continued hardship, suffering, deprivation, and failure

The Goal of Therapy
- to alleviate depression and to prevent its recurrence by helping the patient:

- identify and test *negative cognitions*
- to develop *alternative and more flexible schemas*
- to rehearse both *new cognitive responses* and new behavioral responses

The goal is to change the way a person thinks, and subsequently, to alleviate the depressive disorder

Depressive Premise:

That "A," an event
Causes "B," a feeling



Actually, An event "A," causes a thought "B," with a resultant feeling, "C"

With every event, people have automatic thoughts

example:

Most people who are experiencing psychological distress (Axis I or II) have characteristic cognitive distortions; schemas they typically apply to most everyday events, large and small.

Identifying both the automatic thoughts and the distortions, and then approaching both with a reality test is the key to cognitive therapy

Cognitive Distortions

- **ALL-OR-NOTHING THINKING:** black/white reasoning (if performance falls short of perfect you see yourself as a total failure)
- **OVERGENERALIZATION:** you see a single negative event as a never-ending pattern of defeat
- **MENTAL FILTER:** You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened

- **DISQUALIFYING THE POSITIVE:** you reject positive experiences by insisting they "don't count"
- **JUMPING TO CONCLUSIONS:** you make a negative interpretation even though there are no definite facts that convincingly support your conclusion
 - **mind reading:** arbitrarily conclude someone is reacting negatively toward you without checking it out
 - **fortune telling:** anticipate things will turn out badly and are sure your pre-diction is an already established fact

- **MAGNIFICATION (CATASTROPHIZING) OR MINIMIZATION:** you exaggerate the importance of things (your goof-up or someone else's achievement), or inappropriately shrink things (your achievements)
- **EMOTIONAL REASONING:** you assume that your negative emotions necessarily reflect the way things really are
- **SHOULD STATEMENTS:** also "musts" and "oughts" The end result is guilt. When directed at others can result in anger, resentment, and frustration.

- **LABELING AND MISLABELING:** extreme form of overgeneralization "I'm so dumb"
- **PERSONALIZATION:** you see yourself as the cause of some negative event

Cognitive Therapy

- Good for individuals who are motivated to get better (commitment is easy to assess as they have assigned homework)
- Without *severe* AXIS II pathology
- With depressive or anxious symptoms
- Can do in 6-12 sessions
- Can do as group
- Can use principles in day-to-day work

Worksheet

situation	emotion(s) %(0-100)	automatic thoughts	cognitive distortion	rational response

Worksheet

situation	emotion(s) %(0-100)	automatic thoughts	cognitive distortion	rational response
friend walk- ed by	hurt, angry 85%	she must not like me; I must have done some- thing...etc.	jumping to conclusions	?glasses ?lost in thought ?snub (40%)

Worksheet

situation	emotion(s) %(0-100)	automatic thoughts	cognitive distortion	rational response
Lose keys Covey ex. Albertson				

Further Info

FEELING GOOD The New Mood Therapy

David D. Burns, M.D.

*The most effective
tool you have is a
good therapeutic
alliance*

CHAPTER EIGHT

Personality Disorders

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999/2000

Terminal Objectives

At the completion of this lecture the student will understand:

1. The concept of normal vs. disordered personality
2. The three major personality groupings and an impression of the different types
3. The relationship of personality to NAA

Enabling Objectives

- Explain the difference between a personality disorder and traits
- Discuss what is meant by a "healthy" and "unhealthy" defense mechanism, and give two examples of each
- Provide three examples of how specific personality traits may be maladaptive to aviation

References

- **Aviation Psychiatry Handout**
- **Kaplan and Sadock - Comprehensive Textbook of Psychiatry**
- **Disordered Personalities, David J. Robinson***
- **LIFE**
- **EXPERIENCE**
- **INSIGHT**

(Note - the drawings on slides 13, 14, 31, & 78 are from this book and may not be used without the author's permission)

PERSONALITY:

A relatively stable and enduring set of characteristic behavioral and emotional traits

The Personality Types



PERSONALITY DISORDER

- An *enduring* pattern of inner experience and behavior that **deviates markedly** from the expectations of the individual's culture,
 - is **pervasive and inflexible**,
 - has an onset in adolescence or early adulthood,
 - is stable over time,
 - and leads to distress or impairment

PERSONALITY TRAITS

Prominent aspects of the personality exhibited in social and personal contacts

Personality Disorders in the Military

- **56-63% of all military psychiatric diagnoses**
- **four subtypes (antisocial, passive-aggressive, dependent, and borderline) make up 72% of all the PD discharges)**
- **PDs are handled administratively, not medically**
- **remember, in the civilian sector, most of the PDs we see never come to the attention of a mental health professional**

Common Themes of Normality

- strength of character
- ability to learn from experience
- ability to work
- ability to achieve insight
- absence of symptoms/conflict
- ability to experience pleasure without conflict
- flexibility/ability to adjust
- ability to laugh
- ability to love another
- degree of acculturation

Personality traits do *not* a disorder make

WE ALL HAVE THEM!

If we didn't, life would be *really* dull

Remember relationship to NAA

- **If diagnosed with a PD = NAA**
- **If diagnosed with traits that are maladaptive to safety of flight, mission completion, or aircrew coordination = NAA**
- **It's ALL a matter of *degree* and *which* traits: e.g. To be a successful aviator you must have a degree of narcissism (healthy sense of self-confidence) and obsessive compulsive (attention to detail, conscientious)**

Some Theory



Remember: Sometimes a cigar is just a cigar.....

The ego is the mediator between the id and the superego



Ego Defense Development

- The id seeks expression of an impulse
- The superego prohibits the impulse from being expressed
- The conflict produces anxiety
- An ego defense is unconsciously recruited to decrease the anxiety
- A character trait or neurotic symptom is formed

Traits (and disorders) develop over time based upon life experiences, genes, significant or repeated stressors, or psychotherapy.

This is a dynamic process

All of these can modify or alter a person's pattern of perceiving and relating to the world.

Therefore, don't rely on a single, "slice-in-time" conclusion when considering traits

The most normal person can look pretty disordered at times when stressed

Examples of Defenses

- | | |
|----------------------------------|---|
| • Mature (healthy) | • Primitive/Immature (unhealthy) |
| - humor | - denial |
| - suppression | - projection |
| - anticipation | - splitting |
| - altruism | - distortion |
| - sublimation | - blocking |
| • Neurotic (less healthy) | - acting out |
| - intellectualize | - regression |
| - rationalization | - passive aggressive |
| - repression | - somatization |
| - controlling | |

Ego Defenses (cont.)

Personalities become disordered by the maladaptive use of ego defenses, both in terms of which defenses are used, and the extent to which they are used.

We have all used other than healthy defenses at times and exhibited some of the less than admirable traits.

An *understanding* of defensive mechanisms is essential for recognizing and treating Axis II Disorders.

“Understanding the defenses of another person allows us to empathize rather than condemn, to understand rather than dismiss.”
(Vaillant, 1992)

KNOW THYSELF

USE THYSELF

Countertransference

“the therapist’s conscious and appropriate total emotional reaction to the patient.”

(Kernberg 1965)

Use your emotional response to a patient as data to augment the interview and other information

An example of how I use my response to people as data



The Three Groupings
DRAMATIC ERRATIC

- Borderline
- Antisocial
- Narcissistic
- Histrionic

ANXIOUS/FEARFUL

- Dependent
- Avoidant
- Obsessive Compulsive
- (Passive-Aggressive)

ODD/ECCENTRIC

- Schizoid
- Schizotypal
- Paranoid

DRAMATIC ERRATIC

Borderline

"border" between neurosis and psychosis
 primitive defenses

Themes:

- chaotic childhood
- parental neglect/abuse
- impulsivity
- sexual abuse, early sexual activity, promiscuity
- substance abuse/dependence
- fears abandonment, maintains self-destructive relationships
- failure to achieve potential/goals
- frequent SI/gestures (burns, lacerations, etc...)



Personality Traits
that will be maladaptive in
aviation (a generalization)

- Borderline
- Paranoid
- Schizotypal

Histrionic PD

characterized by excessive emotional
expression and attention-seeking
behavior

overly seductive but with shallow
emotion

likes "making an entrance"

Think Scarlett O'Hara at her
flirtatious and manipulative
best; making a staged
appearance coming down the
staircase at Twelve Oaks

Histrionic Themes

- emotional instability
- vanity/egocentricity
- suggestibility and dependence
- self-dramatization
- exhibitionism
- sexual provocativeness
- fear of sexuality
- overreaction and immaturity

Personality Traits that may affect
SAFETY/MISSION/TEAMWORK

- not a team player
- depending on degree of dependency may have difficulty making decisions without reassurance
- overdramatization may negatively affect acceptance by squadron

Narcissistic PD

- Narcissus - mythological figure who scorned the love of others-the goddess Nemesis answered one of the scornees' prayers, "May he who loves not others love himself". Narcissus fell in love with his reflection in a pool. Unable to leave it he pined away and died.
- characterized by grandiosity, lack of empathy, and a need for admiration



- ### Narcissistic Themes
- **condescending attitude**
 - **dwells on observable assets**
 - **hypersensitivity to criticism**
 - **difficulty maintaining a sense of self-esteem**
 - **many fantasies but few accomplishments**
 - **readily blames others**
 - **conspicuous lack of empathy**
 - **highly self-referential**

For your viewing pleasure and edification.

- Personality Traits *that may affect*
SAFETY/MISSION/TEAMWORK
- Narcissistic:**
- **arrogance** - others may be hesitant to criticize or question a decision
 - **grandiosity** - may overestimate abilities in the cockpit
 - **believes is special** - expects to be seen as the best; not as player on a team (role of the wingman)
 - **projects blame** (doesn't learn from post-mission critique)

Antisocial PD

Oldest and best-validated of the PDs:
 "Moral Insanity"

characterized by guiltless, exploitative, and irresponsible behavior with the hallmark being conscious deceit of others

Easy to interview: their "malignant grandiosity" allows easy rapport as long as you are willing to listen to their exploits (let 'em talk)

best evidence for heritability - "soft" neuro signs
 -decreased 5HIAA/low cortical arousal

- ### Antisocial Themes
- **Glibness, shallow emotion**
 - **requires constant stimulation**
 - **criminal versatility**
 - **parole/probation violations**
 - **promiscuity**
 - **juvenile delinquency**
 - **social parasites**
 - **grandiosity**
 - **poor impulse control**
 - **avoids responsibility for actions**
 - **abuse of substances**
 - **superior physical prowess**
 - **behavioral problems as a child**

Personality Traits *that may affect*
MISSION/SAFETY/TEAMWORK

- **Antisocial**
 - may not follow rules (checklists?, flight minimums?)
 - deceitfulness (lie about preflight, filing, etc?)
 - impulsivity (do something dangerous or stupid for kicks)
 - substance use. . . .
 - reckless disregard for safety
 - irresponsible

ANXIOUS/FEARFUL

Dependent PD

Characterized by submissive behavior and excessive needs for emotional support

Happily remains the well-used doormat

Particularly evident in borderline, avoidant, and histrionic personalities as well as in mood and anxiety disorders

The “sidekick” in movies and TV



Dependent Themes

- **Neediness**
- **rarely lives alone**
- **subordinate themselves**
- **at risk for abusive relationships, substance abuse, overmedication**
- **works below level of ability**
- **continually seeks advice**
- **volunteers for unpleasant tasks**
- **may have a “somatic orientation” by expressing concerns through physical complaints**

Avoidant PD

Characterized by inhibition, introversion, and anxiety in social situations.

Considerable overlap with Dependent Personality Disorder

Was previously described as “inadequate” personality disorder.

Avoidant Themes

- feelings of being defective
- low tolerance for dysphoria
- self-criticism
- exaggeration of risks
- abrupt topic changes away from personal matters
- shyness
- fear of rejection
- hypersensitivity to criticism
- "love at a distance."



Personality Traits that may affect MISSION/SAFETY/TEAMWORK

Dependent

- trouble making decisions without reassurance
- won't disagree with others
- lacks self-confidence (not good in an aviator who needs "healthy" narcissism)

• Avoidant

- won't speak up as fears criticism (would hesitate to challenge MC or if flying with senior ranking person)
- also lacks self-confidence in abilities

O-C PD

Hallmarks of the obsessive-compulsive personality disorder are rigidity, perfectionism, orderliness, indecisiveness, interpersonal control, and emotional constriction

They can be VERY difficult to interview as they present info in a very pedantic and circumstantial manner

Rapport can be very difficult to establish because any empathy demonstrated means that they have not solved their problem.



O-C PD Themes

- emotional constriction
- indecisiveness
- fixated with details
- misses "the forest for the trees"
- cerebral rigidity and inflexibility
- hoard money, objects, etc...
- few leisure activities; can't relax
- humorless; lack of spontaneity

Personality Traits *that may affect*
MISSION/SAFETY/TEAMWORK
Obsessive-Compulsive:

- overly preoccupied with lists/details/order to point of not being able to see big picture (can't continue scan during checklist)
- perfectionism to point of inability to make a decision (always weighing choices) - in an emergency must make many decisions - **FAST**
- reluctant to delegate tasks to others - a must in aviation
- rigid, stubborn, and moralistic - qualities may carry over into the cockpit

(Passive-Aggressive PD)

- **Rarely diagnosed in the general population**
- **One of the most common diagnoses in the military although may not lead to administrative separation like the other common PDs**
- **Projection is the common defense - attribute to others the emotion they feel - inevitably leave the recipient feeling frustrated/angry and not knowing why**

Passive-Aggressive Themes

- **procrastination**
- **indecisiveness**
- **constant victimization**
- **forgetting "accidentally on purpose"**
- **obstructiveness**
- **continual conflict with authority**
- **says "yes" but acts "no"**
- **"Yes, but....."**

If someone *really* ticks you off and you can't quite figure out why - it's a P/A person getting the better of you

Personality Traits *that may affect*
MISSION/SAFETY/TEAMWORK

• **Passive-Aggressive:**

- resists functioning at expected level (minor deficiencies may be deadly in aviation)
- projects blame (does not learn from his/her experience or that of others)
- usually lacking in healthy compulsive traits (may procrastinate on checklists and do poor flight prep)
- never a good team player

ODD/ECCENTRIC

Schizotypal PD

Often seem very unusual in interviews. When a nonjudgmental approach toward their irrational thinking is accomplished with empathy, a connection and rapport can be established

Think of the positive signs of schizophrenia

Actively weird (think Addam's Family or Doc in Back to the Future)

Share some biological and physiological findings with schizophrenics (EPs, high VBR, CSF HVA, SPEM)

genetic loading and nurture (parents who are too "something")

Schizotypal Themes

- clairvoyance
- ideas of reference
- suspiciousness
- emotional reasoning
- premonitions
- alternative/fringe interests
- existential concerns
- magical thinking

The Schizoid

Characterized by detachment from others, a restricted range of emotional expression, and a lack of interest in activities

Relate to the negative symptoms of schizophrenia

"I have no need for other people" (a quote from a schizoid patient)

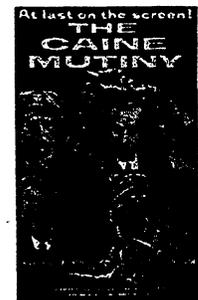
The Schizoid Theme

- prefers to do things alone
- Why bother? Who cares?
- withdrawn/reclusive
- works below potential
- observers, not participants
- lacks interests and hobbies
- deficient motivation
- goes "through the motions"
- may show creativity
- aloof, distant, cold
- humorless
- constricted emotions
- no desire for relationships

The Paranoid PD

Characterized by unwarranted suspiciousness and a tendency to misinterpret the actions of others as threatening, or deliberately harmful.

Easy to recognize in an interview: hypervigilance, anger, hostility, and vindictiveness become obvious early.

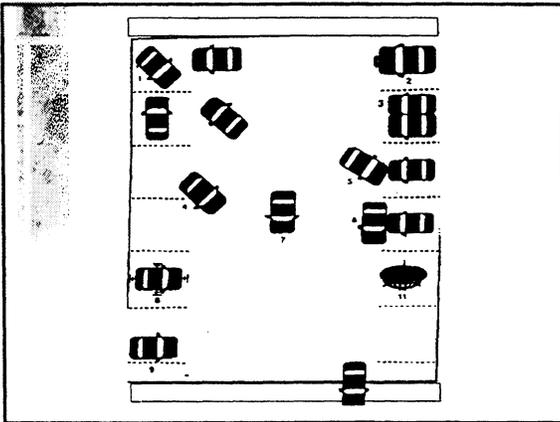


Paranoid Themes

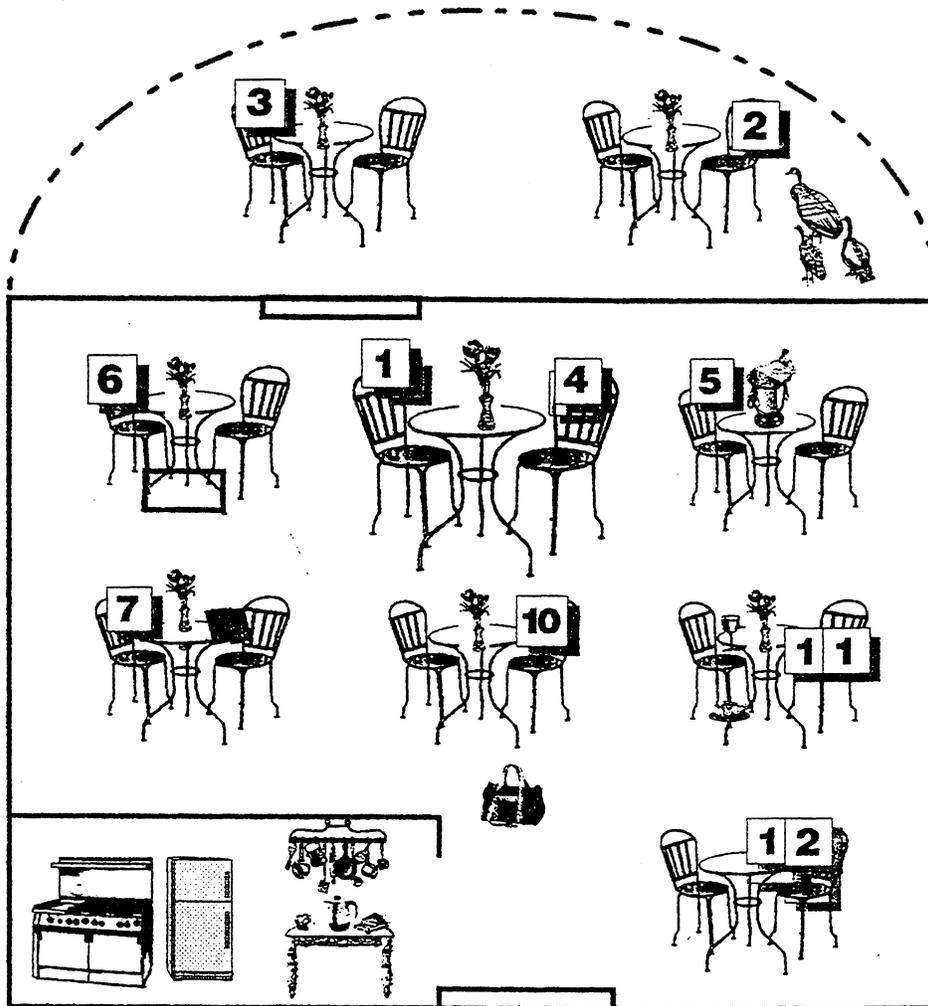
- externalize blame for difficulties-see themselves as continual target of abuse
- repeated difficulty with authority figures
- over-estimate minor events (makes mountains out of molehills)
- search intensely to confirm suspicions to the exclusion of more reasonable answers
- cannot relax; display little to no sense of humor

Paranoid Themes (cont.)

- project envy or even pathological jealousy
- critical of those who they see as weaker, needy, or defective
- difficulty exuding warmth or talking about their insecurities
- cannot trust others
- all motives are questioned



RESTAURANT SEATING AND BEHAVIOR OF THE PDs:



- 1 - **Narcissistic:** Always sits at largest, most prominent table; expects to be seated without a reservation - insisted on being first in this list.
- 2 - **Schizotypal:** Always eats outside so can converse with local birds while sharing meal.
- 3 - **Normal unimpaired patron with healthy traits:** Yes, not everyone is dysfunctional!
- 4 - **Histrionic:** Sits where can see and be seen by all the "beautiful people" - at the end of dinner does a provocative belly dance around the restaurant.
- 5 - **Antisocial:** Asked to leave following a drunken brawl with waiter - stole narcissist's tips on the way out.
- 6 - **Obsessive-Compulsive:** Table must be perfectly aligned at 90 degrees - volunteers to help set up tables so can place cutlery with exactitude and polish crystal.
- 7 - **Dependent:** Always has date order so she doesn't have to decide what to order nor be worried about ordering something more expensive than date; although a nonsmoker sits in smoking section with date.
- 8 - **Schizoid:** Always brings meal and eats in office when he starts his midnight shift.
- 9 - **Avoidant:** Orders out and eats in car to avoid doing something embarrassing in the restaurant.
- 10 - **Passive/Aggressive*:** Places chair and bag in the path of the waiter; blows smoke into nonsmoking section.
- 11 - **Borderline:** hastily left after she threw her Cornish game hen and wine at her dinner partner - he just told her he won't leave his wife. . .
- 12 - **Paranoid:** Never sits with back to doors - watches food being prepared - requested flower be removed because he thought it was bugged.

* - no longer an official PD but they're out there!!!

Personality Disorders

This section begins with a general definition of Personality Disorder that applies to each of the 10 specific Personality Disorders. All Personality Disorders are coded on Axis II.

■ General diagnostic criteria for a Personality Disorder

- A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
 - (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
 - (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
 - (3) interpersonal functioning
 - (4) impulse control
- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
- E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Cluster A Personality Disorders

■ 301.0 Paranoid Personality Disorder

- A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
 - (1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
 - (2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
 - (3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
 - (4) reads hidden demeaning or threatening meanings into benign remarks or events
 - (5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights

- (6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
- (7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

- B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Paranoid Personality Disorder (Premorbid)."

■ 301.20 Schizoid Personality Disorder

- A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
 - (1) neither desires nor enjoys close relationships, including being part of a family
 - (2) almost always chooses solitary activities
 - (3) has little, if any, interest in having sexual experiences with another person
 - (4) takes pleasure in few, if any, activities
 - (5) lacks close friends or confidants other than first-degree relatives
 - (6) appears indifferent to the praise or criticism of others
 - (7) shows emotional coldness, detachment, or flattened affectivity
- B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizoid Personality Disorder (Premorbid)."

■ 301.22 Schizotypal Personality Disorder

- A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
 - (1) ideas of reference (excluding delusions of reference)
 - (2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
 - (3) unusual perceptual experiences, including bodily illusions
 - (4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
 - (5) suspiciousness or paranoid ideation
 - (6) inappropriate or constricted affect
 - (7) behavior or appearance that is odd, eccentric, or peculiar
 - (8) lack of close friends or confidants other than first-degree relatives

- (9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizotypal Personality Disorder (Premorbid)."

Cluster B Personality Disorders

■ 301.7 Antisocial Personality Disorder

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
 - (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
 - (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
 - (3) impulsivity or failure to plan ahead
 - (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
 - (5) reckless disregard for safety of self or others
 - (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
 - (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- B. The individual is at least age 18 years.
- C. There is evidence of Conduct Disorder (see p. 66) with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

■ 301.83 Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- (3) identity disturbance: markedly and persistently unstable self-image or sense of self
- (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

- (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- (7) chronic feelings of emptiness
- (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms

■ 301.50 Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) is uncomfortable in situations in which he or she is not the center of attention
- (2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
- (3) displays rapidly shifting and shallow expression of emotions
- (4) consistently uses physical appearance to draw attention to self
- (5) has a style of speech that is excessively impressionistic and lacking in detail
- (6) shows self-dramatization, theatricality, and exaggerated expression of emotion
- (7) is suggestible, i.e., easily influenced by others or circumstances
- (8) considers relationships to be more intimate than they actually are

■ 301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
- (4) requires excessive admiration
- (5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
- (6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
- (7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
- (8) is often envious of others or believes that others are envious of him or her
- (9) shows arrogant, haughty behaviors or attitudes

301.82 Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
- (2) is unwilling to get involved with people unless certain of being liked
- (3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- (4) is preoccupied with being criticized or rejected in social situations
- (5) is inhibited in new interpersonal situations because of feelings of inadequacy
- (6) views self as socially inept, personally unappealing, or inferior to others
- (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

301.6 Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- (2) needs others to assume responsibility for most major areas of his or her life
- (3) has difficulty expressing disagreement with others because of fear of loss of support or approval. **Note:** Do not include realistic fears of retribution.
- (4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- (5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
- (6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- (7) urgently seeks another relationship as a source of care and support when a close relationship ends
- (8) is unrealistically preoccupied with fears of being left to take care of himself or herself

301.4 Obsessive-Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- (2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
- (3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- (4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- (5) is unable to discard worn-out or worthless objects even when they have no sentimental value
- (6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- (7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
- (8) shows rigidity and stubbornness

301.9 Personality Disorder Not Otherwise Specified

This category is for disorders of personality functioning that do not meet criteria for any specific Personality Disorder. An example is the presence of features of more than one specific Personality Disorder that do not meet the full criteria for any one Personality Disorder ("mixed personality"), but that together cause clinically significant distress or impairment in one or more important areas of functioning (e.g., social or occupational). This category can also be used when the clinician judges that a specific Personality Disorder that is not included in the Classification is appropriate. Examples include depressive personality disorder and passive-aggressive personality disorder (see Appendix B in DSM-IV for suggested research criteria).

request with the concurrence of the separation authority, on the basis of being an alien who no longer wishes to serve.

g. Surviving family member. A servicemember may be separated if authorized per DoD Directive 1315.15 (reference (j)).

h. Other designated physical or mental conditions

(1) A servicemember may be separated on the basis of other designated physical or mental conditions, not amounting to Disability (section D), that potentially interfere with assignment to or performance of duty under the guidance set forth in section A of part 2. Such conditions may include but are not limited to chronic air or seasickness, enuresis, and somnambulism.

(2) Separation processing may not be initiated until the servicemember has been counseled formally concerning deficiencies and has been afforded an opportunity to overcome those deficiencies as reflected in appropriate counseling or personnel records.

(3) Nothing in this provision precludes separation of a servicemember who has such a condition under any other basis set forth under this section (Convenience of the Government) or for any other reason authorized by this instruction.

→ i. Personality disorder

(1) Separation on the basis of personality disorder is authorized only if a psychiatrist or psychologist concludes that per article 15-23 of the Manual of the Medical Department (reference (k)), the servicemember has a personality disorder that is so severe that his or her ability to function effectively in the naval environment is significantly impaired. Personality disorders are described in the Diagnostic and Statistical Manual (DSM-IV) of Mental Disorders (reference (l)).

(2) Separation processing may not be initiated until the servicemember has been formally counseled concerning his or her deficiencies and afforded an opportunity to overcome the deficiencies documented in counseling or personnel records.

* Counseling is not required if the servicemember is determined by competent medical authority to be an immediate danger to himself or others.

(3) Separation for personality disorder is not appropriate when separation is warranted under sections A through P of this part. For example, if separation is warranted on the basis of unsatisfactory performance (section G) or misconduct (section K), the member should not be separated under this section regardless of the existence of a personality disorder.

j. Review action. A servicemember may be separated if he or she is placed on appellate leave awaiting review of a punitive discharge, per DoD Directive 1327.5 (reference (m)), and whose punitive discharge is set aside, suspended, remitted or disapproved during the review process.

k. Reservist becomes a minister. A servicemember of the Reserve who becomes a regular or ordained minister of a religious faith group is entitled, upon his or her request, to discharge from the Naval or Marine Corps Reserve per 10 U.S.C. 1162 (reference (b)), if the servicemember satisfactorily establishes that:

(1) He or she will or does regularly engage in religious preaching and teaching;

(2) The ministry is or will be his or her main and primary calling - a vocation rather than avocation;

(3) His or her standing in the congregation is or will be recognized as that of a minister or leader of a group of lesser members; and

(4) His or her religious faith group is organized exclusively or substantially for religious purposes.

D. Disability.

1. Basis A servicemember may be separated for disability per SECNAVINST 1850.4C (reference (n)).

2. Characterization. Honorable, unless:

a. An Entry Level Separation is required under section C1 or part 3, or

b. Characterization of service as General (under honorable conditions) is warranted under Section B or part 3.

MILPERSMAN 1910-204

Format of NAVPERS 1070/613, Administrative Remarks, for Counseling/Warning

Responsible Office	BUPERS (Pers-83)	Phone:	DSN	224-8245
			COM	(703) 614-8245
			FAX	224-8194

Preparation MILPERSMAN 1070-320 provides general information on the preparation of the NAVPERS 1070/613 and disposition. Use this format when preparing a NAVPERS 1070/613. To document administrative counseling:

(DATE) ADMINISTRATIVE COUNSELING/WARNING

1. You are being retained in the naval service, however, the following deficiencies in your performance and/or conduct are identified: _____
2. The following are recommendations for corrective action: _____
3. Assistance is available through: _____
4. Any further deficiencies in your performance and/or conduct will terminate the reasonable period of time for rehabilitation that this counseling/warning entry provides and may result in disciplinary action and processing for administrative separation. All deficiencies or misconduct during your current enlistment, occurring before and after the date of this action will be considered. Subsequent violation of the UCMJ, conduct resulting in civilian conviction, or deficient conduct or performance of duty could result in an administrative separation Under Other Than Honorable Conditions.
5. This counseling/warning is made to afford you an opportunity to undertake the recommend corrective action. Any failure to adhere to the guidelines cited above will make you eligible for administrative separation.

6. This counseling/warning entry is based upon known deficiencies or misconduct. If any misconduct, unknown to the Navy, is discovered after this counseling/warning is executed, this counseling/warning is null and void.

U.R. COUNSELED
By direction

(DATE): I hereby acknowledge the above NAVPERS 1070/613 entry and desire to
(make a statement/not make a statement).

(Member's Signature)

Witnessed: (person who actually counseled member)

NOTE: If the member refuses to sign, a notation shall be indicated and signed by an officer.



SUICIDE

& Other Psychiatric Emergencies

*D. Wear, CAPT, MC, USN
NOMI Psychiatry*



Terminal Objectives

At the completion of this lecture the student will understand:

1. The epidemiology of suicide in the Navy and the general population
2. The Navy and USMC policies pertinent to a suicide prevention program
3. How to perform a clinical assessment in a psychiatric emergency



Enabling Objectives

- ◆ List two demographic characteristics that place an individual at higher risk of suicide
- ◆ State *the* most important consideration when assessing a patient with a psychiatric emergency
- ◆ Provide three factors from a patient's history that places them at increased risk for suicide



SUICIDAL BEHAVIOR IS A LIFE-THREATENING MEDICAL EMERGENCY



Epidemiology of Suicidal Behavior



IN THE MILITARY

- ◆ Third leading cause of death - 10% of all AD deaths
- ◆ Rate same as civilian: 10-12/100,000 annually
- ◆ An increase in the 15-24 age group (1/3 of AD Navy in this age group)-tripled in the past three decades



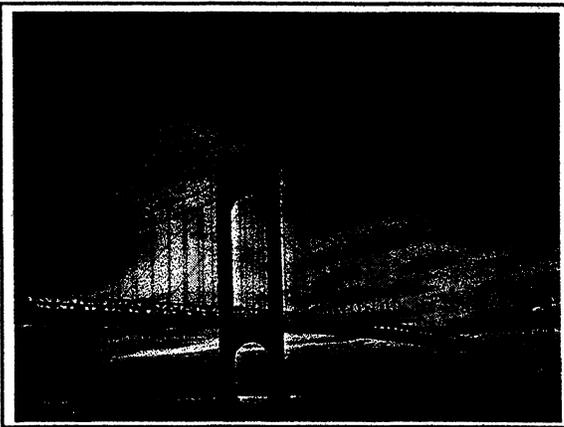
GENERAL POPULATION

- ◆ 9/1,000 people attempt suicide
- ◆ 1/10 endorse suicidal thoughts
- ◆ actual suicide rate has remained stable (increase in the younger group offset by a decrease in the middle-aged group)
- ◆ 30,000 deaths annually in the US (attempts about 10x)
- ◆ One suicide every 20 minutes



SUICIDES BY STATE

- ◆ Lowest rate for both sexes: NJ
- ◆ Highest for men: Nevada and New Mexico
- ◆ Highest for women: Nevada and Wyoming
- ◆ Women in Nevada killed themselves at a higher rate than men in NJ. . . .
- ◆ The #1 suicide site in the world:



More Rates

- ◆ Men commit suicide 3x more than women
- ◆ Women attempt suicide 4x more than men
- ◆ Men use more violent methods
- ◆ Except for the 15-24 age group suicide increases with age: Men peak after 45; women after 55. For men >65: incidence of 40/100,000
- ◆ Elderly account for 25 % of suicides and only 10% of population



Rates Related to Race

- ◆ 3rd leading COD for 15-24 year old males (after accidents and homicide)
- ◆ Whites 2x higher rate than nonwhites - this is misleading in that the rates for the ghetto youth and young Native American and Alaskan Indians far exceed the national average.



Rates (cont.)

- ◆ Religion: suicide rates among Catholic populations are lower than the rates among Protestants and Jews (orthodoxy probably more important than religion)
- ◆ Marital Status: marriage with children greatly less
 - ◆ single, never-married have double the rate for married

Rates (cont.)

- ◆ Marital status (cont.)
 - ◆ Previously married much higher than single:
 - ◆ 24/100,000 among widowed
 - ◆ 40/100,000 among divorced
 - ◆ 69/100,000 among divorced males; 18 for women
- ◆ Occupation
 - ◆ higher the social status, higher the risk
 - ◆ a fall from social status increases the risk
 - ◆ work protects

Rates (cont.)

- ◆ Occupation (cont.)
 - ◆ Female physicians have highest rate: 41/100,000
 - ◆ Male physicians no increase
 - ◆ Psychiatrists > ophthalmologists > anesthesiologists
 - ◆ Other: dentists, musicians, law enforcement officers, lawyers, and insurance agents

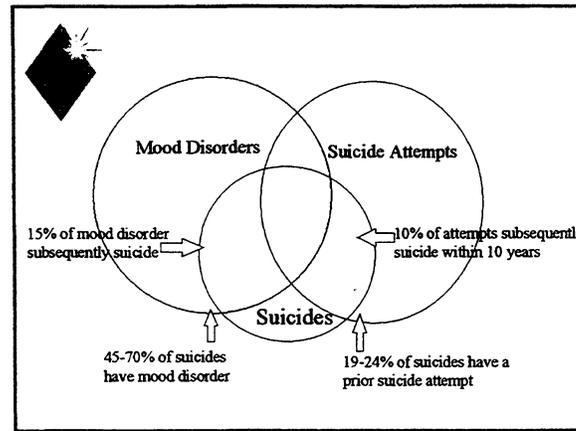
Rates (cont.)

- ◆ Physical health: strong relationship with suicide: postmortem studies show 25-75% of all suicide victims have some physical illness. Health is contributing factor in 11-51%
- ◆ Mental health:
 - ◆ almost 95% of all patients who commit or attempt suicide have a diagnosed mental disorder.

Rates (cont.)

- ◆ Mental Health (cont.)
 - ◆ 80% depression, 10% psychotic disorders, dementia 5%
 - ◆ Risk in mood disorders: 15%
 - ◆ Risk in alcoholism: 15% (270/100,000)
 - ◆ also significant in panic disorder and OC disorder

35-80% of all suicidal behavior is alcohol-related





NAVY RATES

CY 1993-1997
stay at 4-5 per year



*Navy Suicide
Prevention
Policy Overview*



History

- ◆ 1775 - 1980's
 - ◆ Patchwork
 - ◆ No centralized tracking
 - ◆ Medical/Legal/Moral debate
- ◆ 1980's
 - ◆ Quality Of Life (QOL) programs
 - ◆ CO's/OIC's responsibility
 - ◆ Navy specific programs



**Current Navy Policy
Directly Addresses Suicide**

- ◆ OPNAVINST 6100.2 25 Feb 92
 - ◆ Health Promotions Program
- ◆ MILPERSMAN 4210100
 - ◆ Casualty Reporting
- ◆ NAVMEDCOMINST 6520.1A 31 Mar 86
 - ◆ Evaluation and Disposition of Risk



**Current Navy Policy
Directly Addresses Suicide**

- ◆ SECNAVINST 6320.24 14 Dec 94
 - ◆ Mental Health Evaluations Of Members of the Armed Forces
- ◆ SECNAVNOTE 1700 28 Jul 94
 - ◆ Reinvestigation Requests



**Current Navy Policy
Address Significant Risk Factors**

- ◆ MILPERSMAN 3430150
 - ◆ Command response to UA
- ◆ US. Navy Regulations Art.1159
 - ◆ Personally owned weapons
- ◆ OPNAVINST 5354.4B 13 Sep 90
 - ◆ Alcohol Abuse Prevention

Current Navy Policy
Address Significant Risk Factors

- ◆ SECNAVINST 1754.1 12 Jun 84
 - ◆ DoN FSC Program
- ◆ OPNAVINST 6100.2 25 Feb 92
 - ◆ Health Promotions Program

Current USMC Policy
Directly Address Suicide

- ◆ Marine Corps Health Promotions Program - Semper Fit 2000 MCO 6200.4 8 May 92
- ◆ Marine Corps Casualty Procedures Manual P-3040.4C



CO's / OIC's Responsibilities
OPNAVINST 6100.2

- ◆ Develop command program
- ◆ Ensure awareness of local suicide prevention programs
- ◆ Ensure availability of QOL programs

Develop command program

- ◆ Includes:
 - ◆ Suicide response SOP
 - ◆ Command-specific training

Ensure awareness of local suicide prevention programs

- ◆ Minimum requirement:
 - ◆ Orientation programs
 - ◆ GMT/GNT
 - ◆ All other training is considered "proactive"

Ensure availability of QOL programs

Equal Opportunity	Morale Welfare & Recreation
Chaplain Programs (eg. Credo)	Health & Physical Readiness Programs
FSC Programs (eg. FMP, TAP)	Others (eg. PREVENT)

 ***Suicide Activity Definitions***
MILPERSMAN 4210100

- ◆ Part of *Casualty Reporting*
- ◆ Three types:
 - ◆ Suicide
 - ◆ Suicide attempt
 - ◆ Suicide gesture

 ***Suicide Gesture***
MILPERSMAN 4210100

- ◆ An intentional act, suggesting a cry for help, causing self-harm or intent to cause physical self harm *that would not cause death.*

 ***Suicide Attempt***
MILPERSMAN 4210100

- ◆ An intentional act, causing physical self-harm, where *death would have occurred without direct intervention.*

 ***Suicide***
MILPERSMAN 4210100 (CD ROM 1770)

- ◆ *Intentional, self induced death.*

 ***Suicide Activity Definitions***
MILPERSMAN 4210100

- ◆ For reporting purposes, the type of suicide activity is defined solely on the level of *lethality.*

 ***Suicide Activity Reporting***
MILPERSMAN 4210100

- ◆ *All gestures, attempts and suicides must be reported.*
- ◆ Report initiated by:
 - ◆ Parent command or
 - ◆ ISIC or
 - ◆ Local Naval Activity or
 - ◆ Medical Treatment Facility (MTF)



Suicide Activity Reporting

MILPERSMAN 4210100

- ◆ Only method of monitoring all types of injuries.
- ◆ *Not a personnel action* but a casualty/injury action.



Guidelines for Eval/Disposition

NAVMEDCOMINST 6520.1A

- ◆ ALL suicidal risk referrals must be done by mental health professionals
- ◆ Any suicidal act results in a period of observation
- ◆ Outpatient treatment (TPU/MEDHOLD) is appropriate



Mental Health Eval Protections

SECNAVINST 6320.24

- ◆ Prohibits use of mental health evaluation as reprisal
- ◆ Commands may still refer “emergencies” immediately



Reinvestigation Requests

SECNAVNOTE 1700

- ◆ Family may request reinvestigation via SECNAV.
- ◆ Reinvestigation by DoD.
- ◆ Important reason to *always* do a JAGMAN for suicides.



Command Response To UA

MILPERSMAN 3430150

- ◆ Inspect quarters
- ◆ Question cohorts
- ◆ Check hospitals, local law enforcement
- ◆ Check counseling (FSC, MTF, Chaplains)
- ◆ *This list is NOT all inclusive*



Possession of Weapons

U.S. Navy Regulations Art. 1159

- ◆ Personal weapons prohibited:
 - “... on board any ship, aircraft, or any vehicle of the naval service or within any base or other place under naval jurisdiction.”
- ◆ Exceptions set by “proper authority”



Alcohol Abuse Prevention
OPNAVINST 5350.4B

- ◆ Education of alcohol use risk
- ◆ Deglamorization
- ◆ Alternatives to use
- ◆ DAPA knows who has *ever* received treatment
- ◆ Right Spirit
 - ◆ ALNAV 11/96 (Mar 96)
 - ◆ NAVOP 8/96 (Mar 96)



DoN Family Services Center Programs
SECNAVINST 1754.1A

- ◆ Prevention of some problems
 - ◆ Family education programs
- ◆ Early intervention
 - ◆ Family advocacy
- ◆ Any program that improves individual coping skills can be part of suicide prevention



Health Promotions Instruction
OPNAVINST 6100.2

- ◆ Health contributes to better decisions
- ◆ Regular exercise, healthy diet contribute to stress management
- ◆ Responsible alcohol use reduces risk taking, promotes better decision making



Suicidal Behavior
Assessment and
Management



Every suicide act is made with a degree of ambivalence and is a communication



Early Identification and Prevention

- ◆ Causes of Suicide
- ◆ Risk Factors
- ◆ Warning Signs
- ◆ Assessment of Risk
- ◆ Management



Causes of Suicide

- ◆ Loss of Close Relationship
- ◆ Loss of Career and/or Employment
- ◆ Loss of Financial Security
- ◆ Loss of Social Acceptance
- ◆ Loss of Health
- ◆ Loss of Self-Control
- ◆ Loss of Freedom (Disciplinary)



Feelings Associated with Loss (Bereavement)

- ◆ “Psychache” (Intolerable Life Pain)
- ◆ **Hopelessness******(high corroboration with risk)
- ◆ Helplessness
- ◆ Depression
- ◆ Worthlessness (Self-critical)
- ◆ Shame (Self-hate)
- ◆ Agitation/Anxiety/Panic



Risk Factors

- ◆ Relationship Problems
- ◆ Experience with Firearms
- ◆ Alcohol Abuse
- ◆ Unexplained Mood Changes or Depressed Mood
- ◆ Male



Risk Factors (cont.)

- ◆ Previous suicidal behavior
 - ◆ h/o psychiatric d/o
 - ◆ Personality disorder
 - ◆ Unexpected physical disability
 - ◆ FH:
 - ◆ unstable childhood/adolescence
 - ◆ abuse, neglect, rejection by parent
 - ◆ close relationship to someone who committed suicide



Warning Signs

- ◆ Suicidal Talk
 - “I Wish I Were Dead”
 - “IfHappens, I’ll Kill Myself”
 - “No One Cares About Me”
 - “I Just Want All Of This To End”



Warning Signs

- ◆ Suicide Preparation
- ◆ Notes
- ◆ Giving Away Personal Possessions
- ◆ Final Arrangements



Warning Signs

- ◆ Preoccupation with Death
- ◆ Prior Suicide Gestures or Attempts
- ◆ Social Withdrawal
- ◆ Mood Changes



Technique of Assessment

- ◆ *Non judgmental, objective, and empathetic*
- ◆ *Preserve the dignity and avoid humiliating the patient*
- ◆ *Encourage the patient to express concerns and plan*
- ◆ *If made attempt - first stabilize*



Assessment (cont.)

- ◆ *Assess aforementioned risk factors*
- ◆ *If they have a plan:*
 - ◆ *P - what is the proximity to help?*
 - ◆ *A - what is the availability of means?*
 - ◆ *L - what is the lethality of means?*
 - ◆ *S - what is the specificity of the plan?*



Risk Assessment

Follow enclosure (5) in SECNAVINST 6320.2A (Boxer Instruction)

GUIDELINES FOR MENTAL HEALTH EVALUATION FOR IMMINENT DANGEROUSNESS



Assessment (cont.)

- ◆ *Assess information provided by others:*
 - ◆ available support
 - ◆ job stressors
 - ◆ impulsive behavior
 - ◆ safety of where pt will spend next 48 hours
 - ◆ attitudes of family, friends, and command
 - ◆ availability of chaplain, FSC, etc..



Management

- ◆ If suicidal risk is found - must admit to the nearest facility. No one who has made a suicide attempt should be sent home from a treatment facility without a psychiatric evaluation, and in most cases, inpatient evaluation (24-48h).
- ◆ If judged **NOT** a suicidal risk may be returned to the command with written documentation outlining the assessment, dx, and f/u recommendations - notify command by phone or through the escort.



Management

- ◆ *If they are preconfinement and verbalize SIs and there is no AXIS I: may go to Brig*
 - ◆ *“Close Observation”*
- ◆ **THE SAFEST PLACE IS THE BRIG:**
(however, cannot send someone to the brig merely for safety purposes - must be under confinement or preconfinement orders. . .)



Do's and Don'ts

- ◆ *Clarify limitations but explore options and solutions*
- ◆ *Avoid judgmental remarks and observe your body language*
- ◆ *Refrain from making unrealistic reassurances, simple advice, or clichés*



Do's and Don'ts

- ◆ *Don't leave the pt alone*
- ◆ *Include family and friends if available*
- ◆ *Inform the pt of your plans*
- ◆ *Be available during the acute crisis even if hospitalized - visit - don't abandon*
- ◆ *Therapeutic Alliance can't be underestimated (trust, empathy)*



Help the CO/OIC understand why a severely personality disordered member should be ADSEP'd - CUT THEIR LOSSES

***THE MEMBER
WILL “UP THE
ANTE!!!”***



Do's and Don'ts

- ◆ **Contracts**
 - ◆ *a verbal or written “contract” is NOT the bottom line - this can cause a false sense of security (allays the physician's anxiety without having any effect on the patient's suicidal intent) and several recent litigation cases have proven them invalid*
 - ◆ *much better to document that the pt understands the resources available to him/her and document specific risk elements*



Other Psychiatric Emergencies



Anyone at significant risk to harm themselves or someone else can be considered a psychiatric emergency



i.e. - are they suicidal, homicidal, or psychotic?

Keep it simple - first determine the above and then sort out the cause



Clinical Presentations

- ◆ subdued behavior
- ◆ agitated behavior
- ◆ bizarre behavior
- ◆ perfectly normal behavior



How to handle a suicidal, homicidal, or psychotic patient

- ◆ **FIRST AND FOREMOST ENSURE SAFETY** (of patient *and* you)
- ◆ Follow do's/don't already discussed
- ◆ Always err on the conservative side (at minimum contact a psychiatrist or psychologist to discuss case before releasing)
- ◆ Listen to your primary process: if you are uncomfortable being alone with a patient, **DON'T BE ALONE WITH THEM**



Preventive Measures

- ◆ Review your clinic restraint plan - if it doesn't exist get some help and develop one - it may be as simple as call MPs
- ◆ Understand the principles of verbal, chemical, and physical restraint and logistics involved
- ◆ Know policy/legal requirements: suicide evals, Tarasoff, Boxer



Tarasoff - duty to warn/protect

- ◆ Based on 1974 and 1976 CA rulings - MHPs have a duty to protect third parties from the dangerous acts of their clients
- ◆ Requirements vary state-state
- ◆ DoD providers now held to standard as set forth in SECNAVINST 6320.24A (Boxer Law): see handout

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GUIDELINES FOR MENTAL HEALTH EVALUATION
FOR IMMINENT DANGEROUSNESS

Clinical evaluations should include:

I. Record Review

A. Medical Record

1. History of pertinent medical problems and treatment
2. History of substance abuse evaluations and/or treatment
3. History of mental health evaluations and/or treatment

B. Family Advocacy Program (if applicable)

C. Service Personnel Record (if available)

D. Review documentation for disciplinary problems and counseling

II. History

A. History as obtained from the Service member and assessment of reliability

1. History of past violence towards others: ("Have you ever hurt anyone physically? Who? What did you do? How badly was the person hurt? How did you feel about it afterward? How do you feel about it now?")
2. Alcohol and illicit substance abuse/dependence
3. Personal/marital problems
4. Recent losses (job/family)
5. Legal/financial problems
6. History of childhood emotional, sexual and/or physical abuse or witnessing abuse
7. Past psychiatric history

Enclosure (5)

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8. Past medical history and current/recent medications

B. Information from command representative on Service member's behavior, work performance and general functioning

C. Pertinent information from family or friends

III. Mental Status Examination (emphasis on abnormal presentation)

A. Appearance (ability to relate to the examiner, eye contact, hygiene, grooming)

B. Behavior (psychomotor agitation or retardation)

C. Speech (rate, rhythm)

D. Mood (service member's stated predominant mood)

E. Affect

F. Is examiner's observations of member's affect consistent with stated mood?

G. If inconsistent, in what way?

H. Thought Processes: Is there evidence of psychotic symptoms, paranoid thoughts or feelings?

I. Thought Content: What does the service member talk about spontaneously when allowed the opportunity? How does the service member respond to specific questions about the facts or issues which led to his/her psychological evaluation? Is there evidence of an irrational degree of anger, rage, jealousy?

J. Cognition: Is the service member oriented to person, place, time, date, and reason for the evaluation? Can he/she answer simple informational questions and do simple calculations?

K. Assessment of Suicide Potential:

1. Ideation: Do you have or have you had any thoughts about dying or hurting yourself?
2. Intent: Do you wish to die?
3. Plan: Will you hurt yourself or allow yourself to be hurt "accidentally or on purpose?" Do you have access to weapons at work or at home?
4. Behaviors: Have you taken any actions towards hurting yourself; for example, obtaining a weapon with which you could hurt yourself?
5. Attempts: Have you made prior suicide attempts? When? What did you do? How serious was the injury? Did you tell anyone? Did you want to die?

L. Assessment of Current Potential for Future Dangerous Behavior

1. Ideation: Do you have or have you recently had any thoughts to harm or kill anyone?
2. Intent: Do you wish anyone were injured or dead?
3. Plan: Will you hurt or try to kill anyone?
4. Behaviors: Have you verbally threatened to hurt or kill anyone? Have you obtained any weapons?
5. Attempts: Have you physically hurt anyone recently? (Describe.)

IV. Psychological Testing Results (if applicable)

V. Physical Examination and Laboratory Test Results (if applicable)

VI. Assessment Shall Include:

- A. Axis I through III diagnoses, as indicated, and Axis IV and V assessments

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- B. A statement of clinical assessment of risk for dangerous behavior, supported by history obtained from the Service member and others, the mental status examination, pertinent actuarial factors and if pertinent, the physical examination and laboratory studies results.

VII. Recommendation/Plans Shall Address:

- A. Further clinical evaluation and treatment, as indicated.
- B. Precautions taken by the provider and recommendations to the service member's commanding officer.
- C. Recommendations to the service member's commanding officer for administrative management.

VIII. Documentation

- A. Documentation of the history, mental status examination, physical findings, assessment, and recommendations shall be recorded in the inpatient and outpatient record.
- B. In those cases of individuals clinically judged to be imminently or potentially dangerous, a letter documenting the summary of clinical findings, precautions taken by the provider, verbal recommendations made to the service member's commanding officer, and current recommendations shall be forwarded by the mental health care provider via the medical treatment facility commanding officer to the Service member's commanding officer within 1 business day after the evaluation is completed. See enclosure (4).

period (usually less than 24 hours), the service member may be admitted to a psychiatric unit (or medical unit, if a psychiatric unit is not available) for an inpatient evaluation.

(4) The decision to admit a service member for an inpatient mental health evaluation or treatment rests solely with a mental health care provider who has approved hospital admitting privileges. In cases of deployed units, or isolated geographic locations where no mental health care providers are available, a physician, if available, or the senior privileged non-physician provider present, shall take actions and/or make recommendations to the service member's CO to protect the service member's safety and that of others, until such an evaluation can be conducted.

(5) When a mental health care provider performs a comprehensive mental health evaluation and determines a service member is at significantly increased risk of imminently or potentially dangerous behavior, the provider also shall take precautions, contained in reference (a) and this instruction.

(6) The responsible privileged health care provider shall document in the medical record the clinical assessment, including the assessment of risk for imminent dangerousness, treatment plan, progress of treatment, discharge assessment, recommendations to COs, and any notification of potential victims as required by reference (a), subparagraph D7 and this instruction.

→ f. Health Care Providers Duty to Take Precautions Against Threatened Injury

(1) In any case in which a service member has communicated to a health care provider with clinical practice privileges an explicit threat to kill or seriously injure a clearly identified or reasonably identifiable person, or to destroy property under circumstances likely to lead to serious bodily injury or death, and the service member has the apparent intent and ability to carry out the threat, the provider shall take precautions against such threatened injury. Such precautions may include any of the following:

(a) Notification of the service member's CO that the service member is imminently or potentially dangerous.

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(b) Notification of the military and/or civilian law enforcement authority where the threatened injury may occur.

(c) Notification of any identified potential victim(s) of the threats made.

(d) Recommendation to the service member's CO that appropriate precautions be taken.

(e) Admitting the service member to an inpatient psychiatric or medical ward for evaluation and/or treatment of a mental disorder.

(f) Referral of the service member's case to the Service's physical evaluation board per reference (a), subparagraph D6c(1).

(g) Recommendation to the CO the service member be administratively separated for personality disorder per reference (a), subparagraph D6c(2) or other applicable separation authority.

(2) Prior to discharge of an imminently or potentially dangerous service member from inpatient status, a health care provider shall notify the service member's CO, and any identifiable individuals who may be at risk of serious injury from the service member, about the service member's pending discharge.

(3) The health care provider shall document in the medical record the date, time and name of each person and agency contacted when taking precautions against threatened injury.

(4) The health care provider shall inform the service member these precautions have been taken.

g. Recommendations to COs

(1) Upon completion of a mental health examination of an imminently or potentially dangerous service member, the mental health care provider shall immediately provide to the service member's CO a letter that shall address at a minimum the diagnosis, prognosis, treatment plan, and recommendations regarding fitness and suitability for continued service and shall

CHAPTER TEN



Motivation to Fly and Aviator Characteristics

CDR Mark Mittauer

Introduction

- ✦ To understand how aviators function - it is useful to consider what motivates them to fly
- ✦ When evaluating a “failing” aviator - the flight surgeon should consider:
 - 1) if his personality matches that of the successful aviator,
 - 2) if he has a healthy motivation to fly



Past Behavior Predicts Success in Aviation

- ✦ Good impulse control (e.g., absence of MVAs, traffic violations, delinquent behavior, starting fights)
- ✦ “Track record” of accomplishments
- ✦ Healthy stress coping skills (successfully handled significant life events and milestones)
- ✦ Group participation (relationship skills)
- ✦ Leadership skills



Healthy Motivation to Fly

- ✦ Typically began in childhood
- ✦ Involves a counterphobic urge - as one must learn to enjoy an innately terrifying activity
- ✦ Ability to recognize the real dangers of flying and the realistic demands of flight training
- ✦ Ability to transform the aggressive (and sexual?) drives into calculated risk-taking



Historical Clues to Healthy Motivation to Fly

- ✦ Long-standing desire to fly
- ✦ Participation in aviation-related activities (airshows, airplane models, flying lessons)
- ✦ Aviator role model (relative or friend)
- ✦ Enjoyment of (and safe participation in) risky hobbies (sky diving, rock climbing, scuba diving, mosh pits)



Healthy Motivation to Fly (cont.)

- ✦ Never contemplated a non-aviation career
- ✦ Accepts implications of combat flying (e.g., being killed, killing enemy and civilians)
- ✦ Supportive family (spouse or “significant other” and parents)



Clues to Unhealthy Motivation to Fly

- ✦ Impulsive decision to escape family, relationship, or other problems
- ✦ Selecting aviation in response to parental pressure (ex. father is retired combat pilot)
- ✦ Need to compete with and “one up” a domineering parent
- ✦ Selecting aviation to prove “I’m macho” and overcome low self-esteem/inferiority
- ✦ Immature wish to be an aviator (“Topgun wannabee”), instead of fly anything



Reinhart’s Stages in the Aviator’s Life

- ✦ Glamorous years 22-24 yrs.
- ✦ Years of increasing caution 24-28 yrs.
- ✦ Controlled fear of flying 30-38 yrs.
- ✦ Safe years 38+ yrs.



Motivation to Fly Evolves with Aging

- ✦ Young/student aviator:
 - total preoccupation with thrill of flying
 - denial about the dangers of flying (daring)
- ✦ Older aviator:
 - more diverse interests (ex., family)
 - recognizes danger (witnessed or experienced mishaps, ejection, death of aviator friends)



Motivation Evolves (cont.)

- ✦ Seasoned aviator:
 - proud of his/her flying skill and experience
 - more cautious
 - competing interests (military career, family, preparation for civilian career)



Adaptive Defenses in the Healthy Aviator

- ✦ Affiliation
- ✦ Humor (may border on “sick” humor)
- ✦ Sublimation (channel aggressive drive into socially acceptable outlet, like sports)
- ✦ Compartmentalization (e.g., suppresses anger about marital strife while flying)
- ✦ Suppression (of fear of flying)



Defenses (cont.)

- ✦ Denial (“I never think about crashing”)
- ✦ Rationalization (“Flying is less dangerous than driving. There are NATOPS procedures, checkrides, emergency procedures, ejection seats, parachutes,...”)
- ✦ Magical thinking (“I will never have an accident.”)



Evolution of Aviator Personality Traits

- ✦ W.W.I/W.W.II aviators:
- ✦ Few selection criteria
- ✦ Stereotypical macho, aggressive, impulsive thrill-seekers (“Topgun” image)
- ✦ Courageous or foolhardy? - aerial combat, bombing, and strafing done within eyesight of the enemy
- ✦ Spawned colorful legends



Successful Modern Aviator - Characteristics

- ✦ Above-average intelligence (USN - 116; USAF - 123)
- ✦ Supportive parents
- ✦ Calculated risk-taker (accident free) ... yet..
- ✦ Compulsive (obeys NATOPS, checklists)
- ✦ Thinks quickly in emergency and novel situations
- ✦ Strong need for control
- ✦ Independent (but a team player)



Successful Aviator Characteristics (cont.)

- ✦ Big ego (“healthy narcissism”); confident
- ✦ Absence of Axis I or Axis II diagnoses
- ✦ Achievement-driven/action-oriented
- ✦ Avoids introspection (so may “act out” when stressed; externalizes personal probs.)
- ✦ Emotionally reserved (isolates affect; makes friends easily but likes interpersonal distance; uses rational problem-solving)
- ✦ Able to selectively attend to certain inputs



Classic Aviator Personality Studies

- ✦ CAPT Richard Reinhart (1979) - “Outstanding Jet Aviator”
- ✦ Study of 105 fighter pilots - in the top 10% of their peer group (all males)
- ✦ 67% first born (but so are many successful people)
- ✦ Strong parental influence:
 - intense, strong identification with father
 - stable, supportive mother



USAF “Right Stuff” Study

- ✦ Retzlaff and Gibertini (1989)
- ✦ Group I - “Right Stuff”:

dominant	aggressive
impulsive	playful
- ✦ Group II - “OK Stuff”:

less driven	stable
compulsive	less joy in flying
- ✦ Group III-“Wrong Stuff”:

passive	cautious
conforming	less joy in flying



NEO-PI-R (Personality Inventory)

- ✦ Normed for civilian airline pilots and Naval and Marine Corps aviators
- ✦ Five major scales:
 - Neuroticism (low) - generalized anxiety
 - Extroversion (high)
 - Openness (to new experience) - flexible
 - Agreeableness
 - Conscientiousness (high) - does it right
 - Impulsiveness (low)



Personality Test Results

- ◆ Personality testing of successful aviators -reveals similar profiles for men and women



Finis



CHAPTER ELEVEN

Aviator Adaptation/ Career Challenges

CDR Mark Mittauer

Enabling Objectives

- Discuss how aviators are selected
- Discuss the student aviator training path
- Discuss stress coping skills used by successful aviation students
- Discuss signs of poor adaptation to aviation

Enabling Objectives (cont.)

- Discuss interventions for aviation adaptation problems
- Discuss unique challenges advanced aviation training and operational flying

How are Naval Aviator Officers Selected?

- Aviator Selection Test Battery (ASTB):
 - measures personality style, motivation for military and aviation, and cognition
 - minimum score required
- Flight Physical - no formal questions to assess suitability for aviation ("AA" __)
- Selection Boards for ROTC, USNA, OCS applicants

How are Enlisted Aircrew/Air Traffic Controllers Selected?

- Armed Services Vocational Aptitude Battery (ASVAB) - minimum score needed to enlist in the Navy/Marine Corps
- You are selected for the aviation rate if there is as position available (quota system)

Student Naval Aviator (SNA) Flight Training

- OCS, USNA, ROTC
- Aviation Preflight Indoctrination (API)
- Ground School
- Primary Flight Training (16% attrition)
- Intermediate Flight Training
- Advanced Flight Training
- WINGS!
- Replacement Air Group (RAG)

Student Naval Flight Officer (SNFO) Flight Training

- OCS, USNA, ROTC
- Aviation Preflight Indoctrination (API)
- Basic NFO Training
- Intermediate NFO Training
- Advanced NFO Training
- **WINGING!**

Successful Aviator Needs:

- Ability
- Motivation
- Stability:
 - PQ - no Axis I diagnosis
 - AA- no Axis II diagnosis (personality disorder or maladaptive personality traits that adversely impact aircrew coordination, mission execution, or flight safety)

Stress Coping Defenses for Student Aviators

- Flight (withdrawal coping mechanism):
 - “drop on request” (DOR),
 - somatization
 - conversion reaction
- Fight (aggressive coping mechanism):
 - denial (I didn’t make a mistake”)
 - projection (“It was the instructor’s fault”)

Stress Coping Mechanisms (cont.)

- Compromise (healthy coping mechanism):
 - suppression (of fear of death or of making a mistake)
 - denial (“I won’t get a down”)
 - rationalization (“If I get a down, it was the instructor’s fault. I will still get jets!”)
 - magical thinking (“I won’t get a down”)
- Compartmentalization - total of above

Student Aviator Adaptation

- Most adapt to flying within 5 flights, or less
- Goal is to achieve comfort in (and ability to excel in) a multidimensional environment

Signs of Poor Adaptation

- Discomfort flying (fear, severe anxiety)
- Anticipatory anxiety (before the flight)
- “Thrill is gone” (does not enjoy flying; prays for rain)
- “Behind the aircraft” (slow responses, lack of anticipation, “brain lock”)
- Impulsive (but incorrect) control inputs

Poor Adaptation (cont.)

- Chronic fatigue (often occurs when the student eschews exercise, socializing, proper nutrition - and despite adequate sleep)
- Airsickness:
 - initially physiologic (vestibular response)
 - performance anxiety component
 - conditioned response (e.g., fuel smell)

Interventions for Poor Adaptation

- Stress Management Training (e.g., NOMI Psychiatry Department)
- Self-Paced Airsickness Desensitization (SPAD) - at NOMI Internal Medicine - 80% success rate (after unsuccessful trial of phenergan, ephedrine)
- Performance Enhancement Program - uses stress management training, relaxation, etc.

Proposed Study

- NEO-PI-R (personality inventory) given to all Student NFOs (and some winged NFOs for comparison)
- Certain response profile will result in assessment by the Flight Surgeon - and possible referral to NOMI Psychiatry for stress management and evaluation
- MAY reduce DORs and attrites
- NOT a "select out" tool

Challenges in Advanced Student Training

- Resuming junior student status - may be difficult for narcissists
- Solo flights - cause anxiety in dependant students who need excessive reassurance
- More complex aircraft (e.g., prop to jet)
- More complex mission (e.g., carrier ops, night and adverse weather, more challenging mission)

Challenges in Advanced Training (cont.)

- Increased responsibility (e.g., aircraft commander, section leader, flight leader, mission commander)

Challenges in Operational Flying ... and Beyond

- "Nugget" - the junior aviator in his/her first fleet assignment
- Collateral duties
- More frequent deployments - but fewer flight hours
- Supervisory and leadership challenges
- "Dissociated tour" - nonflying tour ("fly a desk")

*Challenges in Operational Flying
(cont.)*

- Military flying vs. civilian airlines (“drive a bus”)
- Military career vs. family

*Challenges for the Flight
Instructor*

- Constant “caretaker” responsibility
- Personal problems (e.g., marital strife, career disappointments)
- Nostalgia for the Fleet
- Narcissistic students - argue about undesired grades
- Dependant students - need excessive nurturing

Questions? Comments?

CHAPTER TWELVE

FEAR OF FLYING

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999

Terminal Objectives

At the completion of this lecture the student will understand:

1. The concept of FEAR OF FLYING
2. The importance of early identification of underlying and related conditions

Enabling Objectives

- Explain the concept of "fear of flying"
- Discuss several predisposing factors
- State the two common stages in an aviator's career
- List three related Axis I conditions
- Discuss the steps you will take if "fear of flying" is raised as a concern

**Fear of Flying is a *CONCEPT*
- not a diagnosis**

**Once you determine this may
be a problem you can then
sort out any *AXIS I and II*
issues**

**Because the aviator does not
present with "fear of flying"
you need to be savvy and
aware of this concept so you
can intervene appropriately
and help the aviator (*and keep
him/her safe!*)**

BACKGROUND

- Flying is a sense of power; it makes the pilot feel in control
- Always a balance between risks vs. rewards
- Those who are *unwilling or unable* to admit to a rational fear use defense mechanisms to reduce the fear
- Frequently a "latent" fear of flying occurs when unhealthy outweigh healthy defense mechanisms

Predisposing Factors

- recurrent training problem
- unhealthy motivation
- career or life goals conflict
- physical or psychological problem

Precipitants

- Professional: job stress, fatigue
- Personal: family, marital problems
- Psychological
 - ⇒ initially healthy defenses may become overwhelmed or distorted if a significant AXIS I Disorder
- Mission Type:
 - ⇒ Low level, night, carrier landings, bombing

- A healthy person can **admit** to the risks and make a conscious well-reasoned decision to continue flying or to quit
- An unhealthy person may recognize the fear but attempts to disguise it through unhealthy defenses
- **This is where the flight surgeon can help the aviator sort out the above**

DEFENSES (conscious)

- **Avoidance**
 - choice of aircraft, canceling hops, etc.
- **Suppression**
 - conscious control of fear and anxiety: **"forced cool"**
- **Compensation by compulsivity**
 - can become maladaptive if inflexible
- **Humor** (OK to a point)
- **(Malingering)**

DEFENSES (unconscious)

- **Denial (healthy in moderation)**
- **Identification (OK)**
 - Gain strength from the group
- **Counterphobia**
 - Getting on schedule first volunteering for dangerous missions, etc.
- **Rationalization/Intellectualization**

DEFENSES (unconscious) - cont.

- **Projection**
 - externalizing one's fears by blaming or criticizing others
- **Compulsive Traits**
 - can be adaptive or maladaptive

FEAR and defenses at different ages

- **EARLY: NAFOD** (no apparent fear of death)
- **MID/LATE: MAWLS** (Middle Age Will to Live Syndrome)

EXAMPLES - a clear cause

- **POST MISHAP**-to deal with acute anxiety following an aircraft mishap
 - ✓ incident debriefing (CISD if loss of life)
 - ✓ rapid return to flight operation - discourage long period out of the aircraft
 - ✓ allow member to vent and shore up defenses

EXAMPLES - no clear cause

- Multiple causes
 - family, career, aging, physical problem, introspection, etc
- Unresolved single traumatic event
- PTSD or other psychiatric disorder
- Appropriate diagnostic and treatment interventions
 - **realistic** dispositional options (?NPQ), help member deal effectively with appropriate emotions (anger, guilt, loss, etc)

RELATED AXIS I DISORDERS **Specific Phobia**

- Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation
- Exposure to the stimulus almost invariably provokes an immediate anxiety response
- The person recognizes that the fear is excessive or unreasonable

Specific Phobia (cont.)

- The phobic situation is avoided or else endured with intense anxiety or distress
- The avoidance, anticipation, or distress in the feared situation interferes significantly with functioning
- **Specify type:**
 - Animal, Natural Environment, Blood-Injection-Injury, Situational, other

CASE

- 33 y o MCM Major with 11y CAD/USMC
- 1100 hours as instructor in AV8B
- currently waived to SGI for "presyncope"
- developed anticipatory anxiety
- currently undergoing **separation**
- ?custody of kids
- initial **denial** → conscious working through
- requesting waiver to SGIII (+multiseat aircraft)

RELATED AXIS I DISORDERS Psychological Factors Affecting Medical Conditions

- A general medical condition (GMC) is present (listed on Axis III)
- Psychological factors adversely affect the GMC in one of the following ways
 - the factors have influenced the course of the GMC as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the GMC

Psychological Factors Affecting Medical Conditions (cont.)

- The factors interfere with the treatment of the GMC
- the factors constitute additional health risks for the individual
- stress-related physiological responses precipitate or exacerbate symptoms of the GMC

Psychological Factors Affecting Medical Conditions (cont.)

- Coded as (*Specified Psychological Factor*) Affecting (*Indicate the GMC*)
- Choose name based on nature of the psychological factors
 - Mental Disorder Affecting . . . , Psychological Symptoms Affecting . . . , Personality Traits or Coping Style Affecting . . . , Maladaptive Health Behaviors Affecting . . . , Stress-Related Physiological Response Affecting . . . , Other Psychological Factors Affecting . . .

Some Clues

- h/o longstanding ambivalence about flying with poorly defended anxiety
- h/o AUTONOMIC HYPERACTIVITY:
 - tension headaches, ulcers, GI sx, etc.
- h/o flying with symptoms and self-medicating
- waiver - *possible in mild cases*

RELATED AXIS I DISORDERS Conversion Disorder

- One or more symptoms or deficits affecting voluntary motor or sensory function that suggests a neurological or other general medical condition
- Psychological factors are judged to be associated with the symptoms or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors

Conversion Disorder (cont.)

- The sx or deficit is not intentionally produced
- The sx or deficit cannot, after appropriate investigation, be fully explained by a GMC, or by the direct effects of a substance, or as a culturally sanctioned experience
- causes clinically significant distress or impairment
- types (motor, sensory, seizures, or mixed)

Conversion Disorder

- Displacement of anxiety
- evidence of unconscious secondary gain
- overuse of denial
- "La belle indifference"
- symptoms disqualify the aviator despite their protests
- poor prognosis

OTHER RELATED FACTORS

- Always consider Adjustment Disorder dx until sorted out - NPQ while symptoms but no waiver required if clean resolution
- Activity-passivity conflicts - can occur in an aviator/NFO with dependent traits
 - does fine in two-seater but chokes when assigned to a single-seater
 - onset usually noted in a post-training command
 - consider if NAA

OTHER RELATED FACTORS

- **Family or marital conflicts**
 - spouse begins to grow apart or family becomes distant (e.g. no one wants anymore moves, etc.)
 - aviator may have to decide to either sacrifice career or lose family
 - Flight surgeon can assist in this process by being a supportive yet uninvolved third party and help arrange family counseling if needed

OTHER RELATED FACTORS

- **The "Brink of Success" Pattern**
 - does well until a few steps from achieving goal
 - look at relationship with dad (both fear of success or fear of failure) (that psychobabble castration fear thing)
- **Accident-Proneness**
 - when so perfectionistic that minor failures result in increased loss of confidence, inability to express anger appropriately

FEAR OF FLYING - Summary

- Poorly defended fears present as vague and multiple somatic symptoms, inconsistent or unprofessional behavior, or dysfunctional personal relationships
- Diagnosis and attempting to sort out underlying dynamics are essential
- Tx is *supportive* - may continue to fly if symptoms are minor
- **CALL US!!!**

THE FAILING AVIATOR

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999/2000

Terminal Objectives

At the completion of this lecture the student will understand:

1. The *concept* of the "Failing Aviator"
2. The importance of early identification of underlying and related conditions
3. The differences between how the typical male vice female "failing" aviators present

Enabling Objectives

- Explain the concept of "the failing aviator"
- Discuss the characteristic defenses used by the healthy aviator
- State the role of the Human Factors Council in early identification of "the failing aviator"
- List two characteristic differences between how the male and female "failing aviator" presents

Background

- Like "fear of flying," the "failing" aviator is NOT a diagnosis, but a concept to keep in mind.
- Also like f-o-f, when considering the failing aviator, flying is almost never the real stressor
- Historically seen in the older or middle-aged aviator with multiple stressors

Background (cont.)

- The aviator population today is much more heterogeneous regarding gender and ethnicity
- Failing aviators today may present with more subtle signs and symptoms of poor stress

The Failing Aviator

- References:
 - Handout
 - COMNAVIAIRPACINST 5420.2B/
COMNAVIAIRLANTINST 5420.5C/
COMNAVIAIRESFORINST 5420.2
(SOP on Human Factors Council and Human Factors Board) - encl. (5)

Personality Traits of Healthy Aviators

- Healthy aviators of both sexes score about the same on certain standard psychological tests
- NEO-PI-R: emotionally stable
conscientious
extroverted
- Healthy traits: self-reliant
achievement-oriented
adventurous

Coping Styles of Healthy Aviators

- **DEFENSE MECHANISMS:**
denial rationalization
suppression intellectualization
- **COMPARTMENTALIZATION:**
ability to ignore (exclude from consciousness) distractions that do not contribute to flying

Healthy Female Aviators

- Compared to females in the general population, female aviators are:
less modest
less agreeable
more emotionally stable
more conscientious

Why is it difficult to recognize the failing aviator?

- The failing aviator is reluctant to acknowledge problems:
 - denial is a normal defense
 - stigma of psychiatric illness
 - fear of extrusion from the group
 - belief that psychiatric treatment equates with the end of flying

Difficulties in Recognizing the Failing Aviator

- The "organization" (peers, supervisors, flight surgeon) is **reluctant to express concerns** about its members
- Reasons:
 - fear of "contamination" (if it happened to "Viper", it could happen to me)
 - reluctance to admit that "one of us" failed

Underlying Stressors for the Failing Male Aviator

- **Relationship/family problem**
- **Work problem:**
 - personality conflict with the chain-of-command
 - middle management problem
 - poor fitness report
 - feeling that work not appreciated
- **\$\$\$-career-family/risks-rewards**
- **Environment (machine)/Mission**
 - deployments, moves, pulling G's, etc.

Behavior of the Failing Male Aviator (Dully, 1983)

- "Acting out"
- displays of bravado
- macho posturing
- abandon
- risk-taking behavior:
 - sexual promiscuity
 - dangerous sports
 - alcohol abuse
 - reckless driving
 - flying "outside the envelope"

Most Common Diagnoses

- Adjustment Disorders
- Marital Problem
- Phase of Life Problem
- Maladaptive Personality Traits (O/C, Narcissistic, P/A)

How will the failing female aviator behave?

Literature is sparse!

- Berg and Moore (1997): "Behavioral and Emotional Manifestations of the Failing Female Aviator"
- Conclusion: ***The failing female aviator may present in less dramatic fashion and thus may not be recognized by the flight surgeon***

Why might female and minority aviators deny feeling stressed?

- Same reasons as the "guys"
- Need for acceptance by the established group of male aviators
- Desire to avoid being labeled as a "weak" female

Study by Berg and Moore (96)

- Case review of 12 failing female aviators (referred for psychiatric evaluation due to performance difficulties)
- Student and designated Naval pilots and flight officers

Symptoms of Failing Female Aviators

- anxiety
- insomnia
- tearfulness
- depression
- irritability
- In general, emotional distress was internalized
- guilt
- hopelessness
- lowered self-esteem
- loneliness

Behaviors of Failing Female Aviators

- aviation performance problems
- social withdrawal
- **NO** impulsive risk-taking!

Underlying Concerns for these Women

- 75% relationship problem
- 25% death of a close friend in an aviation mishap
- 25% perceived sexual harassment/ hostile work environment

Psychiatric Diagnosis

- Adjustment Disorder was most common
- Same diagnoses as the male failing aviators

ROLE OF THE FLIGHT SURGEON

- **Cannot be overstated!!!**
- Your effectiveness in the squadron hinges on your ability to detect problems early, intervene **effectively** (decisively and fairly balancing the needs of the Navy and the individual), and get the aviator flying **SAFELY**
- Ensure active participation in the HFC/B

Recommendations for the Flight Surgeon

- Be aware of the differences among stressed aviators regarding:
 - different precipitating stresses
 - different symptoms (internalized distress)
 - different behaviors (less "acting out")
- Some stressed aviators may present with more subtle symptoms and behaviors

Don't have the first indication of the failing aviator be a mishap -



Particularly if your own defenses got in the way (i.e. the proverbial ostrich with their head in the sand = denial). ***Sometimes it takes courage to make the right decision***

PEARL

Do not rely on the aviator to determine if he/she can or cannot compartmentalize!

Any aviator using typical defenses will say they are doing "fine."



CHAPTER THIRTEEN

Group Dynamics in Aviation/ Integration of the F.S. into the Squadron

CDR Mark Mittauer

Group Dynamics in Aviation

Introduction

- Group dynamics influence the behavior of individual members
note: group may mean a squadron, aircrew in one aircraft, etc.
- Individual aviators assume a variety of roles (professional and personal) in a group - that change over time

Introduction (cont.)

- These roles:
 - a) affect how the aviator is perceived
 - b) enable the aviator to influence the group
- The flight surgeon is more effective if he/she understands these dynamics

Roles an Aviator may Assume in a Squadron

- operational assignment (ex. pilot-in-command, section lead, mission cmdr.)
- administrative assignment (collateral duty)
- mentor
- friend
- romantic partner
- social position (ex. "party animal")

Individual Characteristics Influence Others' Behavior

- flying experience (could be negative influence if one ignores checklists, SOP)
- integrity/trustworthiness
- personality style:
 - avoidant - unassertive in emergency
 - narcissistic - demands attention; "pouts"
- appearance - attractive people are perceived as > intelligent and capable; may get extra attention from instructors

(Cont.)

- gender/race:
 - women and minority males may not be accepted as readily - leading to lower morale and self-esteem
 - women may experience male instructors as either more, or less, demanding
 - women may encounter hostility and unwelcome sexual advances

(Cont.)

- The individual has more influence on the group if he/she shares common characteristics with the group
- The flight surgeon will have more credibility as a *physician* if he flies and lives with the squadron members and studies about flying (ex. takes NATOPS exams)

Cockpit Configuration Influences Behavior

- Side-by-side seating:
 - EA6B, P-3, S-3, helos (CH-46, CH-53)
 - Crewmember in left seat is "dominant", but there is more equality than in tandem (front-and-back) seating
 - advantage - more effective communication as both auditory and visual exchanges occur
 - problem - creates (and reduces) anxiety

(Cont.)

- Tandem (front-and-back) seating:
 - Cobra, F-18, F-14, T34C "Radial Interceptor"
 - potentially less communication (auditory only)
 - may create isolation or paranoia (ex. one crewmember is less talkative)

Mission (Role) Influences Behavior

- The pilot's "stick" and the NFO's radar "scope" are symbols of authority - and may create a power struggle
- In two seat fighters - the RIO "runs the show" (navigates and communicates) prior to the "merge" (dogfight), then the pilot assumes control
- In the P-3, the TACCO (RIO) is in charge of the mission

(Cont.)

- Radar operators (enlisted or junior officers) control aircraft from the ground, the aircraft carrier, or airborne (ex. E2)
- This may create passive-aggressive or defiant behavior (by the "controlled" aircraft) - that may compromise safety

Crew Composition Influences Behavior

- Rank may not match experience/skill in the same aircraft (or group of planes)
ex. the "hot stick" (most skilled pilot) may be junior and less experienced
note: senior officers may fly less often
- Squadron position may not match flight mission responsibility
ex. LT (pilot) flying with Skipper (RIO)

(Cont.)

- In a multi-crew plane - an "identified leader" may wrest control from the "appointed leader" (pilot-in-command)

Group Behavior Influences Individual Behavior

- Risk-taking behavior increases:
- The group empowers the individual member - to overcome feelings of inadequacy
why? - risk-taking is a desirable social value
- the media highlights national heroes and film/TV action figures who are risk-takers

(Cont.)

- A group collectively assumes more risk than an individual
why? - diffusion of blame for a bad outcome
- feelings of anonymity in a group
- Conformity increases:
why? - the group rewards conforming behavior in new members

(Cont.)

- Loss of inhibition increases:
- The group overrides an individual's maintenance of socially acceptable behavior
- A crewmember is more likely to make the same bad or incorrect decision as his peers

Group Culture

- Each squadron has a distinct "personality style" that evolves over time
- Squadron achievements and lore are passed down through the "corporate memory" with (perhaps) embellishment
- The squadron reputation bonds and motivates the members and boosts morale (ex. jet vs. helo "slow movers"; fighter "jocks" vs. attack "pukes")

Group Rituals

- Each squadron has rituals (formal and informal) that reinforce the group identity
- Call signs (nick names) remind the aviator of his place in the "pecking order"
note: new FS called "Quack"
- The squadron may have initiation rituals (good-natured ridicule)

Unique Aviation Group Behavior

- The "jackal" phenomenon:
- A squadron member may be "extruded" when he oversteps acceptable behavior standards (formal and informal)
- The flight surgeon may be asked to medically "dispose" of the member

Recommendations for the Flight Surgeon with "Jackals":

- Maintain your professional integrity
- Insist on extensive documentation
- Consult (senior or group flight surgeon; NOMI Psychiatry)
- Handle administratively if appropriate (ex. FNAEB, FFPB, HFB)
- Psychiatric referral only if appropriate (use SECNAVINST 6320.24A - Boxer Law)

Squadron Reaction to Death

- Normal grief stages: shock, denial, bargaining, sadness, acceptance
- Healthy defenses: rationalization, suppression, compartmentalization, "gallows humor"
- "Wake for a day": allows rapid integration of the mishap and return to "business as usual" (flying)

Squadron Death (cont.)

- The flight surgeon should watch for unhealthy behavior: projection of blame, "splitting", survivor guilt, excessive denial, "acting out" (alcoholic binges)
- Consider requesting a Critical Incident Stress Debrief (CISD)
- CISD available via chaplains, Family Service Center, local Mental Health Department, SPRINT Teams

Integration of the Flight Surgeon into the Squadron

Desired Qualities of the Flight Surgeon

- Be confident and comfortable with making independent medical decisions
- Know and obey the boundaries of your authority and expertise (know when to consult and refer)
- Maintain your professional medical integrity ("do the right thing" when there are conflicts of interest; document in the medical record)

The Ideal Flight Surgeon (cont.)

- Become a trusted member of the squadron:
 - dress the part (USMC uniform/grooming)
 - attend all squadron social functions
 - study NATOPS
 - visit the non-aviators and learn about their jobs ("safety" inspections)

The Ideal Flight Surgeon (cont.)

- Be humble. Accept (with grace) ridicule, criticism, and initial avoidance by your aviators
- Be flexible in balancing divided loyalties to several squadrons - and between the squadron and clinic
- Be a model Naval officer. Practice "leadership by example."

The Ideal Flight Surgeon (cont.)

- Be comfortable with aviator behavior that may violate your moral code (adultery, sexual promiscuity, alcohol use, coarse language)
 - maintain confidentiality
 - do not be judgmental
 - maintain your integrity
 - take action when behavior is unsafe

Challenges for the Flight Surgeon

- "Special" patients:
 - ex. CO, XO, Admiral, Wing Staff
 - try to treat all patients equally (document!)
 - complete a thorough medical eval
 - consult Senior FS and peers
- Multiple responsibilities - to squadron, clinic, hospital, other squadron(s):
 - set limits; be assertive and lobby hard for adequate squadron time

Challenges for the Flight Surgeon (cont.)

- Divided loyalty - to the patient and the Navy/Marine Corps:
 - inform your patient that the CO must be aware of serious medical/psychiatric conditions that may compromise flight safety, aircrew coordination, or individual safety (ex. alcohol abuse, suicidal ideation)

**Challenges for the Flight Surgeon
(cont.)**

- Medical care for family members:
 - find out if it is feasible to care for your aviators' family members before you agree
 - avoid undue familiarity (ADULTERY)
 - strictly maintain your aviators' confidences! ("what happens on the road, stays on the road")

**Challenges
(cont.)**

- Squadron social "cliques":
 - be available, and a friend, to all squadron officers
 - maintain confidentiality about medical conditions and personal issues of individual aviators

Finis

CHAPTER FOURTEEN

AEROMEDICAL DISPOSITION

I. OVERVIEW

- A. During these training sessions, the Student Flight Surgeon class will be divided into small groups of 5-7 students. Each group will be given a sample case vignette to evaluate. These case studies will illustrate common psychiatric presentations which the Flight Surgeon must be able to handle effectively. The Aviation Psychiatry Final Exam will follow this format although students will be required to work individually.
- B. Be aware that these cases may illustrate any, or all, of the following:
1. Axis I disorders
 2. Axis II disorders
 3. V codes
 4. Administrative or disciplinary problems
- C. After reading each case vignette, students will address the following:
1. What is the differential diagnosis? The most likely diagnosis? (Remember, there may be diagnoses on multiple axes, or more than one diagnosis on the same axis.)
 2. What further work-up, if any, should be done? (Remember to think about possible organicity.)
 3. What treatment would you recommend? (Hospitalization, outpatient treatment, psychotherapy, psychotropic medication, behavioral therapy, AA, etc.)
 4. What is the aeromedical disposition? What is the General Duty disposition? (Do they need a Medical Board?)
 5. Can this condition be waived? If so, when? Upon what conditions is a waiver contingent? What supporting documents should be included in the waiver package?
- D. The groups will select a member to present their findings to the class, and discussion will be led by the instructor regarding appropriate assessment and disposition.

II. PSYCHIATRIC CRITERIA TO EVALUATE SUITABILITY FOR AVIATION DUTIES

This chapter provides information about various psychiatric disorders and the associated aeromedical concerns for each

disorder. As well it discusses waiver criteria and follow-up requirements where applicable. These guidelines are necessary to preserve the functional capability of our operational forces.

A. CONDITION: ALCOHOL ABUSE OR DEPENDENCE

1. **AEROMEDICAL CONCERNS:** Ethyl alcohol has a depressant effect on brain mechanisms. Subtle performance effects such as procedural errors, increased reaction time and inattentiveness can occur after low doses. More importantly, it can cause and potentiate disorientation including production of positional alcohol nystagmus and vertigo, and impaired ability to suppress inappropriate vestibular nystagmus. This susceptibility exists long into the "hangover" period. Ingestion of alcohol causes reduced G_z tolerance by 0.1-0.4 G. Alcohol is associated with a higher accident rate in both ground and flight operations. Chronic ingestion with CNS, GI, and CV effects can produce performance degradation in flight and ground jobs.
2. **DISCUSSION:** In terms of acute intoxication, alcohol is implicated in about 16% of general aviation fatal accidents. The risk of liver damage in a man drinking 80gm ethanol (equivalent to one 6-pack of beer, 3-4 mixed drinks or 4-6 glasses of wine; the corresponding figure for females is about 50gm) a day for some years has been reported as 15%. Acute alcohol intoxication can produce arrhythmias which usually disappear quickly but can leave moderate conduction delays for up to one week (the "holiday heart" syndrome).
3. **PREVIOUS ALCOHOL ABUSE/DEPENDENCE TREATMENT:** To ensure that all aviation personnel with a history of alcohol abuse or dependence are properly identified and followed, all aviation physical exams shall include the following question on the appropriate questionnaire (SF-93 or 6120/2): "Have you ever been diagnosed or had any level of treatment for alcohol abuse or dependence?" Positive responses should be correlated with a current valid waiver. If none exists, waiver should be requested via the member's chain of command per the following guidelines and the diagnosis should be noted on the member's problems summary sheet in the health record.
4. **TREATMENT:** Level II (Alcohol Abuse) or Level III inpatient program (Alcohol Dependence). In 1996, a Level II/III **outpatient** program, Intensive Outpatient Program (IOP), will be opened at certain Navy Alcohol Rehabilitation Centers. Waiver packages should specifically note if member attended IOP instead of Level II or III, and a treatment summary must be included.

5. **WAIVER:**

a. **ALCOHOL ABUSE AND DEPENDENCE:** NPQ for aviation. Waiver is possible 90 days* after the patient has:

- 1) Maintained positive attitude and unqualified acknowledgment of his/her alcohol disorder;
- 2) Successfully completed the appropriate treatment program (Level II or III; IOP);
- 3) Remained abstinent without need for medication;
- 4) Maintained satisfactory participation with documentation in an organized alcohol recovery program (AA, Rational Recovery).

* Return to flight status should occur no sooner than 30 days after satisfactory completion of a treatment program. The 30 day option should be used in those cases with minimal risk factors, minimal social stressors, and unqualified participation in treatment/recovery.

6. **NONCOMPLIANCE:** Continued denial of an alcohol problem and/or refusal to abstain from alcohol following treatment is CD for continued aviation status and requires submission of SF 88/93 to MED-236. Any relapse requires re-evaluation by FS/DAPA/ARD to determine potential for retreatment vs. permanent disqualification.

7. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** See BUMEDINST 5300.8. 1) A grounding PE should be submitted upon diagnosis of Alcohol Dependence or Abuse. A complete flight physical should be submitted with the initial waiver request. Thereafter, physicals for BUMED endorsement are required only on an annual basis for waiver continuance; 2) FS narrative assessment of member's recovery including Mental Status Exam; 3) Copy of Level II or III or IOP treatment summary (first time only); 4) FS and DAPA's statement to document aftercare including AA attendance; 5) Psychiatric evaluation by a credentialed psychiatrist or clinical psychologist at initial waiver request, then annually while in aftercare. SECNAVINST 6320.24 (Boxer Law) does not apply in these cases because the psychiatric evaluation is required by instruction; 6) Internal Medicine evaluation at initial request if indicated.

8. **FOLLOW-UP REQUIREMENTS:** See BUMEDINST 5300.8. The member must visit the following professionals at the intervals specified:

- a. Flight Surgeon. Monthly for the first 12 months, then every three months for the remaining two years.
- b. DAPA. Monthly for the entire 3 years with documentation of AA attendance.

c. Credentialed Psychiatrist/Clinical Psychologist. Annually while in aftercare. If deployed at the time of annual physical, the psychological evaluation may be performed by the flight surgeon (as taught in the Student Flight Surgeon curriculum) and submitted with the request for continuance of waiver.

B. CONDITION: ATTEMPTED SUICIDE

1. **AEROMEDICAL CONCERNS:** There is a risk that a person may make an attempt which will involve the safety of others (pilots sometimes use their aircraft as the instrument of suicide).
2. **DISCUSSION:** Of those who make a suicidal gesture, 66% are involved in acute personal crisis and many will have ingested alcohol within 6 hours of the attempt. Within one year, 20 will repeat the attempt and 2% will be successful. There is an underlying personality disorder in 20-25% of cases.
3. **TREATMENT:** Treatment is based on the individual's psychiatric diagnosis. However, suicide attempts associated with most Axis I and Axis II diagnoses other than Adjustment Disorder or V codes are incompatible with aviation duty.
4. **FOLLOW-UP REQUIREMENTS:** Follow-up psychiatric care is at the discretion of the treating mental health provider, and the frequency should be clearly stated in the psychiatric evaluation or hospital discharge summary.
5. **WAIVER:** "Suicide attempt" itself is a behavior, not a DSM-IV psychiatric diagnosis. Waivers are based on the psychiatric diagnosis of which the suicide attempt is a manifestation. If the suicide attempt is the manifestation of a Personality Disorder, the patient is NAA. If the suicide attempt is a manifestation of an Adjustment Disorder, the pt would be PQ after the Adjustment Disorder resolves.
6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** All suicidal ideation and attempts by Navy personnel require a psychiatric evaluation, and psychiatric hospitalization if warranted.

C. CONDITION: ANXIETY DISORDERS

1. **AEROMEDICAL CONCERNS:** The symptoms may produce distraction in flight with autonomic symptoms as well. Panic attacks can produce sudden incapacitation.
2. **DISCUSSION:** Patients with PTSD, Panic Disorder, and GAD may complain of palpitations, dizziness, headaches,

shortness of breath, tremulousness, and impaired concentration and memory. OCD patients complain of obsessional thoughts and/or compulsive rituals which interfere with functioning. Long term prognosis is controversial; however, over 50% may recover within a year with appropriate treatment. Panic disorder has a high rate of recurrence, and is associated with increased mortality from cardiovascular disease and suicide.

3. **TREATMENT:** Medication is incompatible with flying status. Behavioral therapy, including relaxation, biofeedback, and anxiety management is permitted in a flying status if the symptomatology is so mild that it does not meet the criteria for Panic Disorder, PTSD, Generalized Anxiety Disorder, or Obsessive Compulsive Disorder. Medication and behavioral therapy may certainly be used while the patient is on a Limited Duty Board and grounded.
4. **FOLLOW-UP REQUIREMENTS:** Psychiatric follow-up for the anxiety disorders is at the discretion of the treating mental health provider. Patients on Limited Duty Status are generally seen at least monthly in follow-up. After one year off medications, asymptomatic and out of active treatment, the patient should receive a psychiatric evaluation to verify that there has been no recurrence for inclusion with the waiver request.
5. **WAIVER:**
 - a. **PANIC DISORDER/PTSD/GENERALIZED ANXIETY DISORDER/OBSESSIVE COMPULSIVE DISORDER:** NPQ for aviation. Treatment should occur under the auspices of a Limited Duty Medical Board. Waiver may be requested when asymptomatic, off medications, and out of active treatment for one year.
 - b. **SPECIFIC PHOBIAS:** NPQ only if they impact on performance or flight safety.
 - c. **SOCIAL PHOBIAS:** NPQ if the behavior impacts on flight performance. Refer via medical board for Departmental Review.
 - d. **ACUTE STRESS DISORDER:** NPQ for aviation. Waiver may be requested when patient has been asymptomatic, off medications, and out of active treatment for at least six months.
6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** Psychiatric evaluation and treatment summary, and Medical Board reports if indicated.

D. CONDITION: MOOD DISORDERS AND ADJUSTMENT DISORDERS

1. **AEROMEDICAL CONCERNS:** Mood disorders and Adjustment Disorders are associated with decreased concentration, inattention, indecisiveness, fatigue, insomnia, agitation, and psychosis, all of which are incompatible with aviation duties. Risk of suicide is 15%, highest of all mental disorders. There is a strong association with substance abuse.
2. **DISCUSSION:** 15% of depressed patients eventually commit suicide. 50-75% of affected patients have a recurrent episode. Acute major depression is treatable in 80% of patients. 20-30% of Dysthymic patients develop subsequent depression or mania.
3. **TREATMENT:** Psychotropic medications and psychotherapy for depressive/manic symptoms are not compatible with aviation duties.
4. **FOLLOW-UP REQUIREMENTS:** Psychiatric follow-up is at the discretion of the mental health provider. Adjustment Disorders diagnosed by mental health personnel are not considered resolved until a mental health provider makes that statement in the patient's health record. Mood Disorders are generally seen at least monthly while on limited duty. After the one year period off medications and asymptomatic out of active treatment, a psychiatric evaluation is required to verify that there has been no recurrence of symptoms for inclusion with the waiver request.
5. **WAIVER:**
 - a. **ADJUSTMENT DISORDERS:** NPQ during the active phase. When resolved, patient is PQ, no waiver required.
 - b. **MAJOR DEPRESSIVE DISORDER/ DYSTHYMIA/ DEPRESSIVE DISORDER, NOS:** NPQ for aviation. Treatment should occur under auspices of Limited Duty Medical Board. Waiver may be requested when asymptomatic, off medications, and out of active treatment for one year.
 - c. **RECURRENT MAJOR DEPRESSIVE DISORDER/MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES:** NPQ, No Waiver.
 - d. **BIPOLAR DISORDER:** NPQ for aviation, no waiver. Should be referred to central Physical Evaluation Board for fitness for general duty/retention.
6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** Psychiatric evaluation and treatment summary, and Medical Board reports if applicable.

E. CONDITION: PERSONALITY DISORDERS

1. **AEROMEDICAL CONCERNS.** Maladaptive personality traits may lead to flight safety problems. Aeronautical adaptability involves a person's coping mechanisms, personality style and defense mechanisms that may impact on the ability to undergo training, safety in aviation environments, and the ability to interact in a harmonious way with other crew members. Certain personality traits may produce thrill seeking behavior, conflicts with authority, emotional lability, questionable judgment and poor impulse control, or inflexibility incompatible with the rigors of aviation duty.
2. **DISCUSSION:** Psychometric testing such as the MMPI may be abnormal in Class 2 personnel, but is frequently normal in SG I/ SG II personnel. The stress of military life frequently exacerbates maladaptive behavior and the diagnosis becomes apparent in the operational environment.
3. **TREATMENT:** Treatment of Personality Disorders requires long term intensive psychotherapy which is incompatible with aviation duty and usually not practical in the military.
4. **WAIVER:** Personality Disorders are NAA. Maladaptive traits which negatively impact safety of flight, crew coordination, or mission execution are also NAA. Once an individual is found NAA, it is unlikely that (s)he will be found AA at a later date. Thus, no waivers can be considered for aeronautical adaptability. If, however, the patient demonstrates over a period of 2-3 years substantial personality maturation in terms of his/her ability to (a) sustain the stressors of the aviation environment, (b) work in harmony with other members, and (c) stabilize his/her personal life and turmoil, (s)he may be considered for reevaluation by a Psychiatrist or Psychologist, preferably at NAMI Psychiatry provided both the patient and his/her command have a strong desire to return to flight status. Questions of aeronautical adaptability of designated aviation personnel should be referred to NAMI Psychiatry by telephone consultation or referral for further evaluation.
5. **INFORMATION REQUIRED FOR NAMI EVALUATION:** The diagnosis is largely based on documentation and evidence of prior counseling of the history of pervasive behaviors or traits that are characteristic of the person's recent and long term functioning (since early adulthood) which cause social or occupational impairment or subjective distress. Psychiatric evaluation is required to clarify suitability for general and special duty.

F. CONDITION: PSYCHOTIC DISORDERS

1. **AEROMEDICAL CONCERNS:** Symptoms of aeromedical concern include eccentric behavior, illogical thinking, hallucinations, social withdrawal and a risk of suicide. Recurrence is abrupt, unpredictable and incapacitating in aviation.
2. **DISCUSSION:** Increased vulnerability to stress is considered lifelong in these disorders. In schizophrenia, 1/3 will lead somewhat normal lives; 1/3 will continue to have significant symptoms; 1/3 require frequent hospitalization and chronic care. 50% of schizophrenics make a suicide attempt, and 10% will succeed.
3. **TREATMENT:** Antipsychotic medications and close psychiatric follow-up care are incompatible with aviation duty.
4. **FOLLOW-UP REQUIREMENTS:** Psychiatric follow-up is at the discretion of the treating psychiatrist. The majority of these disorders require Physical Evaluation Boards due to their incompatibility with general duty.
5. **WAIVER:**
 - a. SCHIZOPHRENIA/SCHIZOPHRENIFORM DISORDER/SCHIZOAFFECTIVE DISORDER/DELUSIONAL DISORDER/BRIEF PSYCHOTIC DISORDER WITHOUT MARKED STRESSORS/AND PSYCHOTIC DISORDER NOS: NPQ for aviation, no waiver. Should be referred to Central Physical Evaluation Board for fitness for general duty/retention.
 - b. BRIEF PSYCHOTIC DISORDER WITH MARKED STRESSORS (BRIEF REACTIVE PSYCHOSIS): NPQ for aviation. Treatment should occur under the auspices of a Limited Duty Board. Waiver may be requested when asymptomatic, off medications, and out of active treatment for one year in a Full Duty status. These cases are handled on a case-by-case basis depending on the prognostic factors of the case.
 - c. SUBSTANCE-INDUCED PSYCHOTIC DISORDER: Substance-induced Psychotic Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to medication use is PQ when resolved, as long as the "substance" inducing the psychosis was not alcohol or illicit drugs.
 - d. PSYCHOTIC DISORDER DUE TO GENERAL MEDICAL CONDITION: PQ when resolved if the precipitating organic factors are identified and considered not likely to recur. Physical illness or other disorders causing persistent

delirium are permanently disqualifying and should be referred to a medical board.

6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** Psychiatric evaluation, treatment summary and copy of Medical Board if applicable.

G. CONDITION: SEXUAL DISORDERS

1. **AEROMEDICAL CONCERNS:** Sexual Disorders include both Sexual Dysfunctions (sexual arousal, desire, orgasm disorders) and Paraphilias. Generally, sexual dysfunctions do not impact on a person's aviation performance. The paraphilias, however, such as exhibitionism, voyeurism and tranvestic fetishism may impact on aviation performance. Such patients exhibit compulsive behavior, impaired judgement and poor impulse control, and certain legal ramifications may cause the person to be inattentive to detail and a safety risk.
2. **DISCUSSION:** Paraphilic activity often has a compulsive/impulsive quality. Patients may repeatedly engage in deviant behavior, and this behavior increases when the patient feels stressed, anxious, or depressed. The legal consequences generally preclude treatment within the military.
3. **TREATMENT:** The treatment of sexual desire/aversion/arousal/pain/orgasm disorders generally involves behavioral techniques which should not preclude aviation duty. Use of medication is incompatible with aviation duty. Treatment of paraphilias is less successful, and generally requires long-term treatment.
4. **FOLLOW-UP REQUIREMENTS:** Psychiatric follow-up is at the discretion of the mental health provider in those cases in which treatment is deemed necessary.
5. **WAIVER:** Paraphilias are generally NPQ. Waiver requests are handled on a case-by-case basis by NAMI Psychiatry after the patient has completed treatment and been asymptomatic for an adequate time period. However, many cases are handled by administrative disposition due to legal implications and impact on good order and discipline. Sexual dysfunctions may be PQ if they do not impact aviation performance.
6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** Psychiatric evaluation and treatment summary with a statement from the FS regarding the individual's performance.

H. CONDITION: IMPULSE CONTROL DISORDERS

1. **AEROMEDICAL CONCERNS:** Stereotyped or impulsive behavior may lead to aviation safety problems. These disorders involve an

inability to resist acting on an impulse that is dangerous to oneself or others, and that is characterized by a sense of pleasure when gratified.

2. **DISCUSSION:** Differential diagnosis should include substance abuse, temporal lobe epilepsy, head trauma, bipolar disorder (manic), and antisocial personality disorder. The diagnosis is usually not made if the behavior occurs only in the context of another Axis I or Axis II disorder such as schizophrenia, bipolar disorder, or adjustment disorder.
3. **TREATMENT:** Psychotropic medications used with Intermittent Explosive Disorder and Trichotillomania are incompatible with aviation duty. Pathological gambling and kleptomania are generally treated with behavior therapy.
4. **FOLLOW-UP REQUIREMENTS:** Follow-up psychiatric care is at the discretion of the mental health provider in those cases in which it is deemed necessary.
5. **WAIVER:** Impulse Control Disorders (Intermittent Explosive Disorder, Kleptomania, Pathological Gambling, Pyromania, Trichotillomania) are NPQ for aviation, no waiver. These cases are handled on a case-by-case basis, and questions should be referred to NAMI Psychiatry via telephone consultation or referral for formal evaluation.
6. **INFORMATION REQUIRED FOR NAMI EVALUATION:** Previous psychiatric evaluation and flight surgeon's documentation outlining any social, occupational, administrative, or legal problems of the patient.

I. CONDITION: SOMATOFORM DISORDERS AND FACTITIOUS DISORDERS

1. **AEROMEDICAL CONCERNS.** These disorders have a chronic course and patients make repeated visits to physicians due to multiple physical or somatic complaints. Patients with factitious disorders may seriously injure themselves (injecting feces, swallowing ground glass, injecting insulin) and are at extreme risk in the aviation environment.
2. **DISCUSSION:** 15-30% of patients with hypochondriacal disorders have physical problems. 30% of conversion disorders have associated physical illness. Factitious disorders have a high risk of substance abuse over time.
3. **TREATMENT:** Treatment offers little hope of return to flight status in Factitious Disorders. These patients are rarely motivated for psychotherapy, and generally change physicians when confronted. The psychotropic medications used in Somatoform Disorders are incompatible with aviation status.

4. **FOLLOW-UP REQUIREMENTS:** Follow-up psychiatric care is at the discretion of the treating mental health provider. Patients are generally seen at least monthly while on Limited Duty.
5. **WAIVER:** These disorders are NPQ. They should be referred to a Medical Board for treatment. Waivers may be considered for those rare cases which are successfully treated on a Limited Duty Board and remain asymptomatic and off medications for one year in a Full Duty status.
6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** Psychiatric evaluation, copy of Medical Board if applicable, and flight surgeon's narrative outlining any social, occupational, administrative, or legal problems of the patient.

J. CONDITION: EATING DISORDERS

1. **AEROMEDICAL CONCERNS.** Eating disorders can cause potentially life-threatening metabolic alkalosis, hypochloremia, and hypokalemia which can have drastic implications for aviation safety. Anxiety and depressive symptoms are common, and suicide is a risk.
2. **DISCUSSION:** Relapse rate is high. In long term follow-up of anorexia, 40% recover, 30% improve, and 30% are chronic. Anorexia is potentially fatal in 5-12% of cases. Bulimia is often associated with alcohol abuse.
3. **TREATMENT:** Treatment is very difficult and involves intensive long term therapy, group therapy, and possibly pharmacotherapy, all of which is incompatible with aviation duty.
4. **FOLLOW-UP REQUIREMENTS:** Follow-up psychiatric care for those patients retained is at the discretion of the treating mental health provider, but should involve at least monthly follow-up.
5. **WAIVER:** Eating Disorders (Anorexia, Bulimia, and Eating Disorders NOS) are NPQ for aviation. These cases should be treated under the auspices of a Limited Duty Medical Board if the member is retained; however, many of them will be administratively separated. Waiver may be considered on a case-by-case basis if the patient is off medication, asymptomatic, and out of active treatment for one year. These patients must meet the minimum aviation weight standards.
6. **INFORMATION REQUIRED FOR WAIVER RECOMMENDATION:** Psychiatric evaluation, copy of Medical Board if applicable, and flight surgeon's narrative outlining any social, occupational, administrative, or legal problems of the patient.



Combat Psychiatry

CDR Mark Mittauer

Outline - Discuss:

- ✦ Symptoms of Combat Stress Reactions (CSR)
- ✦ Risk Factors for CSR
- ✦ Management of CSR (NOT TREATMENT)
- ✦ Prevention of CSR
- ✦ Combat Stress Control Unit



How Does One Overcome the Fear of Combat?

- ✦ “Delusion” of Omnipotence
- ✦ Strong faith in leaders
- ✦ Conviction that an individual’s peers will protect him/her



Combat Stress Reaction (CSR)

- ✦ Also called Combat Fatigue
- ✦ A normal condition that occurs in normal combatants under abnormal circumstances
- ✦ A person’s psychological defenses are overwhelmed and the person is temporarily unable to fight or function
- ✦ Combat Stress Reaction is (intentionally) NOT a psychiatric diagnosis



Combat Psychiatry’s Goal

- ✦ To prepare as many personnel as possible for combat (and thus to prevent Combat Stress Reactions)
- ✦ To restore personnel with Combat Stress Reactions to full duty
- ✦ To recognize and treat CSR - to prevent development of psychiatric illness and disability
- ✦ Some dispute that less morbidity with RTD



Normal Physiological Reactions to Combat

- ✦ muscle tension/tremor/cramping/shaking
- ✦ diaphoresis (sweating)
- ✦ tachycardia (increased pulse rate)
- ✦ increased blood pressure
- ✦ tachypnea (increased breathing rate)/hyperventilation
- ✦ diarrhea and increased urinary frequency



Normal Psychological Reactions to Combat

- ✦ fear/panic attacks
- ✦ apathy
- ✦ depression
- ✦ crying
- ✦ irritability/anger
- ✦ insomnia
- ✦ fatigue/exhaustion
- helplessness
- frustration
- poor concentration



Behavioral Symptoms of Chronic Combat Exposure

- ✦ hypervigilance
- ✦ exaggerated startle response (hyperarousal)
- ✦ alcohol or drug abuse
- ✦ “sick” humor
- ✦ excessive griping
- ✦ withdrawal from the group
- ✦ psychomotor retardation



Severe Symptoms of CSR

- ✦ overwhelming fear/inconsolable/hysterical
- ✦ fleeing combat/refusal to fight/fear of flying
- ✦ self mutilation/suicide attempt
- ✦ incoherent speech
- ✦ severe cognitive deficits (e.g., thought blocking, memory deficits, disorientation)
- ✦ psychosis



Severe Symptoms of CSR (cont.)

- ✦ catatonia (immobility; excessive motor activity)
- ✦ mania
- ✦ somatoform or conversion symptoms (loss of motor or sensory function WITHOUT a neurological or medical cause)
- ✦ inappropriate alcohol or drug use
- ✦ dissociation (amnesia, depersonalization, feeling “dazed”)



Classification of CSR

- ✦ Often classified as mild, moderate, or severe
- ✦ Formal DSM-IV diagnoses avoided, unless the member will be transferred “to the rear” for lengthy and definitive psychiatric care (e.g., Brief Psychotic Disorder or Major Depressive Disorder)
- ✦ This avoids giving the patient the impression that he has a medical or psychiatric illness



How to Differentiate CSR from Normal Combat Anxiety

- ✦ symptoms interfere with functioning
- ✦ symptoms exceed those of peers
- ✦ symptoms persist long after exposure to the trauma ends



Organic Causes of Combat Stress Symptoms

- ✦ **Be alert for these potentially fatal conditions!**
- ✦ head injury (intracranial bleed)
- ✦ spinal cord injury
- ✦ infectious disease (including biological war)
- ✦ dehydration
- ✦ severe sleep deprivation



Other Organic Causes ...

- ✦ illicit drug toxicity or withdrawal (e.g., stimulants, benzodiazepines, hallucinogens)
- ✦ prescribed drug toxicity or withdrawal (e.g., stimulants)
- ✦ alcohol intoxication/withdrawal
- ✦ chemical or nuclear warfare agents
- ✦ chem. warfare antidotes (ex. atropine anticholinergic psychosis)



Risk Factors for Combat Stress

- ✦ Environmental/Situational
- ✦ Operational/Organizational
- ✦ Individual
- ✦ Phase of Deployment



Environmental/Situational Risk Factors

- ✦ adverse weather, terrain, noise
- ✦ greater combat intensity and duration
- ✦ viewing wounded (esp. violent, grotesque)
- ✦ suffering a wound
- ✦ participating in atrocities
- ✦ surprise attack (e.g., ambush, terrorism)
- ✦ nuclear, biological, or chemical attack ~~and~~ threat - leads to anticipatory anxiety
- ✦ wearing MOPP gear



(Cont.)

- ✦ inadequate food
- ✦ poor sleep; fatigue; inadequate leisure time
- ✦ poor field living conditions and sanitation
- ✦ infectious disease (presence and threat)
- ✦ well equipped and trained enemy with high morale and motivation
- ✦ lack of knowledge about mission effectiveness



General Rule:

- ✦ **Increased risk for combat stress with:**
 - greater number of risk factors
 - increased severity of risk factors
 - longer exposure to risk factors



Operational/Organizational Risk Factors

- ✦ poor leadership
- ✦ poor unit cohesion/morale (small unit)
- ✦ uncertainty about mission or role
- ✦ lack of home support for mission
- ✦ lack of/inaccurate information
- ✦ poor training (for combat and field living)



(Cont.)

- ✦ outdated equipment (lack of confidence in the equipment capability) e.g. aircraft
- ✦ unpredictable deployment schedule (due to “rightsizing” and dynamic, unstable international situation)



(Cont.)

- ✦ deploying units with recently assigned personnel that have not trained together (reservists)
- ✦ support troops (non-combat front line):
 - often less well trained to cope with combat
 - helpless feeling at fixed base
 - exposure to carnage and suffering (of combatants and civilians) e.g. body handlers
 - harassed by locals (and cannot retaliate)
 - surprise attack (missile; aircraft)



Individual Risk Factors

- ✦ age (very young or older)
- ✦ single/divorced
- ✦ minority or female facing discrimination
- ✦ lower rank (USNS Comfort study)
- ✦ lack of training and experience
- ✦ lack of commitment to the cause
- ✦ recently assigned to the unit
- ✦ worry about family at home (reservists)
- ✦ financial stress (e.g. reservists lose job)



(Cont.)

- ✦ Poor physical fitness (gauge: combat exercise endurance; NOT PRT score)
- ✦ medical illness
- ✦ preexisting psychiatric disorders (and risk for illness):
 - Axis I (e.g. PTSD from prior combat)
 - Axis II personality disorder or maladaptive personality traits



Phase of Deployment Affects Stress

- ✦ Predeployment phase:
 - boredom, anticipatory anxiety, substance abuse
- ✦ Initial phase:
 - high operations tempo, new environment, exhaustion, marked anxiety
- ✦ Middle phase:
 - family concerns



(Cont.)

- ✦ Final phase:
 - stressful if delay in leaving
- ✦ Homecoming:
 - grief for loss of unit camaraderie
 - family readjustment



Risk Factors for Aviators (literature sparse)

- ✦ threat of injury from anti-aircraft fire
- ✦ injury or death of friends
- ✦ participation in destructive mission
- ✦ sustained operations (SUSOPS) - delays treatment of CSR
- ✦ wearing Aircrew Chemical Defense Ensemble



CSR Symptoms in Aircrew

- ✦ careless flying
- ✦ cognitive impairment
- ✦ ingrained physical skills preserved, despite severe fatigue

Note: aviators less prone to CSR than non-aviators



Medical Units at Risk for Combat Stress

- ✦ may not train together as a unit (if mobilized for the specific conflict)
- ✦ sometimes uncertain about their role
- ✦ lack of support from the combat unit that the medical unit supports (as do not train together; perceived as draining supplies from the combat unit)
- ✦ less risk for CSR if previously handled corpses, or cared for dying patients



Special Challenges for Mental Health Units

- ✦ not perceived as important by the line and medical units - as deal with intangible, nonphysical injury - *and return stressed combatants to duty!*
- ✦ may not receive adequate support from the medical unit to which the mental health unit is attached



How Common are Combat Stress Reactions?

- ✦ estimate 1 combat stress casualty for every 2 to 5 wounded
- ✦ more combat stress casualties (relative to wounded) in NBC environment
- ✦ Desert Storm: anticipating longer war, the Army predicted that there would be 1400 combat stress cases per week (with 1400 returned to duty)



When do Combat Stress Casualties Occur?

- ✦ incidence high in the first week of combat (40% in one article)
- ✦ incidence declines to a stable rate over the next 3 weeks
- ✦ anticipate an increase again after one month (prolonged combat)



Treatment of Combat Stress Reactions

- ✦ **BICEPS** mnemonic
- ✦ Brevity: brief treatment with goal of return to duty within 3 days (or medevac to rear)
- ✦ Immediacy:
 - treat as soon as condition recognized
 - begin with aid by buddies, chaplain, corpsman, etc.



BICEPS Treatment (cont.)

- ✦ Centrality:
 - treat CSR victims in one area (not part of medical unit) to avoid labeling as "ill"
 - may occur near combat unit, battalion aid station, or field hospital (safety is key)
- ✦ Expectancy: instill message that person is having acceptable and temporary reaction to stress - and will soon return to duty



BICEPS Treatment (cont.)

- ✦ Proximity: treat near member's unit (bond)
- ✦ Simplicity: - avoid psychotherapy
 - avoid drugs (Ambien/benzo. ok for sleep)
 - food, sleep, shower, clean uniform
 - routine - exercise, work detail (in rate/MOS), occupational therapy, games
 - military milieu ensures discipline



Simplicity (cont.)

- ✦ **Critical Incident Stress Debrief (CISD)**
- ✦ group session(s) - to discuss member's role, behavior, thoughts and feelings in combat
- ✦ teaches normality and universality of combat stress behavior, coping skills, and stress management



CISD (cont.)

- ✦ Some dispute that CISD effective, especially if performed before the traumatic event has ended
- ✦ CISD may increase morbidity
- ✦ Participants generally deem it useful



Prognosis for Treated Combat Stress Reactions

- ✦ One article predicts that 30 % of the casualties will return to duty within 24 hours - and 90 % return to duty within 72 hours
- ✦ Another article noted a recurrence rate of 7 % for treated members - and noted that 5 % will require medevac out of theater
- ✦ A few members will need to be assigned to support duties, instead of combat duties



What DSM-IV Diagnoses Apply to CSR Patients?

- ✦ Combatants who suffer CSR - and ultimately return to duty may have:
- ✦ V- Codes
- ✦ Adjustment Disorders (+/- suicidal ideation)
- ✦ Somatoform Disorders (e.g. Conversion Disorder)
- ✦ Malingering



Who Needs to be Medevaced?

- ✦ Major Depressive Disorder
- ✦ Bipolar Disorder
- ✦ Psychotic Disorders
- ✦ Anxiety Disorders (Panic Disorder, PTSD)
- ✦ Patients with persistent suicidal ideation
- ✦ Unresolved/recurrent Conversion Disorder
- ✦ Dissociative Disorders (amnesia)
- ✦ Commanders with any CSR presentation



Techniques to Prevent Combat Stress

- ✦ Do not deploy members with psychiatric diagnoses
- ✦ physical fitness
- ✦ the best possible food, shelter, sanitation
- ✦ adequate sleep (minimum 4 hours; 30 minute naps) - and leisure time
- note: aviators need 8 hours of sleep with "no fly" days



Prevention (cont.)

- ✦ cycle units in and out of combat (rest days)
- ✦ realistic, frequent training (field living, combat, NBC)
- ✦ teach small unit leadership
- ✦ maintain "busy" training schedule



Prevention (cont.)

- ✦ provide modern equipment
- ✦ ensure families are cared for
- ✦ rotate units into and out of the theater as a unit (maintain unit integrity)
- ✦ leaders live with and visit troops often
- ✦ disseminate accurate information often
- ✦ maintain discipline



Prevention (cont.)

- ◆ promote morale and unit cohesion (awards ceremonies, distinctive insignia)
- ◆ team building (routine, sports, combat exercise)
- ◆ “buddy system” (assign veterans to care for new troops)
- ◆ teach about CSR - symptoms, prevention, “buddy aid”



(Cont.)

- ◆ teach stress management (ex., sleep hygiene)
- ◆ teach about NBC and disease threat - and prevention
- ◆ memorial services and mourning rituals



Prevention (cont.)

- ◆ **Critical Incident Stress Debrief** (longer process/small groups/interactive) vs. **Defusing** (brief session/larger group/noninteractive) - after:
 - training mishap (injury or death)
 - enemy or friendly fire casualties
 - accidental injury (detonation of mine)
 - exposure to dead, wounded, civilian suffering



Combat Stress Control (CSC)

- ◆ In future conflicts (combat, peacekeeping missions), military mental health assets will perform a variety of functions
- ◆ **Combat Stress Control (CSC) Units** - will be created to train with and deploy with operational units (ship and ground)



Combat Stress Control (cont.)

- ◆ The basic CSC element will likely be a highly mobile 3 person team that will travel with, (and circuit-ride among), forward “tip-of-the-spear” combat units
- ◆ The future Marine may have a personal computer that can monitor sleep quantity, stress levels, etc.



Combat Stress Control Functions

- ◆ Consultation to unit leaders about mental health concerns (assess unit stress, morale)
- ◆ Teaching (before deployment/combat):
 - stress management
 - Combat Stress Reaction prevention
 - Critical Incident Stress Debrief/Defusing
 - recognition of CSR
 - “buddy aid” for CSR victims



CSC Functions (cont.)

- ✦ Triage of psychiatric patients
- ✦ Brief stress debriefs/CISD - for wounded, medical personnel, litter bearers, morgue personnel, combatants, etc. (**may** prevent Acute Stress Disorder, PTSD, Depression)
- ✦ Restoration - Combat Stress Reaction "treatment" to restore members to full duty within 72 hours (and return to own units) ex. - at battalion aid station



CSC Functions (cont.)

- ✦ Reconditioning - more intensive treatment in rear field hospital(1 to 2 weeks) to avoid medevac out of theater
- ✦ Demobilization and pre-homecoming briefs:
 - ease the cease-fire "letdown"
 - help prevent careless behavior (ex. handling unexploded ordnance)
 - prepare for home/reunite with loved ones



Special Challenges for Combat Stress Control Units

- ✦ Locate fast moving, mechanized combat units that need CISD
- ✦ Return combatants (recovered from CSR) to individual units (up to 72 hours later!)
- ✦ Current USMC doctrine: does not include return to unit after medevac to amphibs



"Peacekeeping"/Humanitarian Missions

- ✦ Significant incidence of Combat Stress Reactions, PTSD, and other psych. illness
- ✦ Factors:
 - changing rules of engagement
 - unclear goals/success hard to measure
 - hostile civilians
 - exposure to refugee poverty, atrocities
 - miserable living conditions for military



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Finis



Rapid Trauma Intervention

By Mark Lessard, PhD
850-452-8674

Introduction

- ◆ The goal of this class is to familiarize people with the effects of trauma and interventions to minimize its long-term consequences.

Traumatic Stress

- ◆ Exposure to a crisis
- ◆ Turning Point
- ◆ Sudden
- ◆ Unexpected
- ◆ Dangerous
- ◆ Immediacy
- ◆ Unusual

Crises/personal

- ◆ Rape
- ◆ Assault
- ◆ Auto Accident
- ◆ Burglary

Crises/group

- ◆ Natural Disasters
- ◆ Plane Crashes
- ◆ Terrorism
- ◆ Operational Deaths

Victims

- ◆ Primary
- ◆ Secondary
- ◆ Tertiary

Crises/Professional

- ◆ Firefighters
- ◆ Police
- ◆ Paramedics
- ◆ Physicians
- ◆ Witnesses

Stress Response

- ◆ Environmental Stimulus
- ◆ Cognitive Interpretation
- ◆ Affective Integration
- ◆ Psychobiological Response

Effects of Stress/Cognitive

- ◆ Confusion
- ◆ Poor Concentration
- ◆ Impaired ability to make decisions
- ◆ Memory

Effects/Physical

- ◆ Diaphoresis
- ◆ Dizziness
- ◆ Increased Heart Rate
- ◆ Elevated Blood Pressure
- ◆ Headaches
- ◆ Gastrointestinal Upset

Effects /Emotional

- ◆ Shock/Numbing
- ◆ Anger
- ◆ Grief/Sadness
- ◆ Helplessness

Effects/Behavioral

- ◆ CHANGE
- ◆ Appetite
- ◆ Sleep
- ◆ Hygiene
- ◆ Social

Acute Stress Disorder

- ◆ Exposure to Trauma
- ◆ Dissociation
- ◆ Re-experiencing
- ◆ Avoidance
- ◆ Hyperarousal
- ◆ Two days-- four weeks

Posttraumatic Stress Disorder

- ◆ Exposure
- ◆ Re-experiencing
- ◆ Avoidance
- ◆ Hyperarousal
- ◆ Greater than one month

Who Will Be Most Affected?

- | | |
|--------------------------------|----------------------|
| ◆ Personal Factors: | ◆ Traumatic Factors: |
| ◆ Neurologic
Predisposition | ◆ Duration |
| ◆ Background | ◆ Intensity |
| ◆ Internal Locus of
Control | |

Intervention/Prevention

- ◆ Education/ Stress Management
- ◆ Trauma Immunization
- ◆ Standard Processing With Peers

Intervention/On Scene/SAFE-R

- ◆ Stimulation Reduction
- ◆ Acknowledgment of Crisis
- ◆ Facilitation of Understanding
- ◆ Encourage Effective Coping
- ◆ Restoration of Independent Functioning

Intervention/Debriefing

- ◆ Introduction
- ◆ Fact
- ◆ Thought
- ◆ Reactions
- ◆ Symptom
- ◆ Teaching
- ◆ Re-entry

Intervention/Defusing

- ◆ Abbreviated version of the debriefing
- ◆ Introduction
- ◆ Exploration
- ◆ Information

Intervention/Demobilization

- ◆ For Massive, ongoing, operations
- ◆ Information regarding effects of stress and referral possibilities
- ◆ Hot-line

Mechanism of Action

- ◆ "Trauma Membrane"
- ◆ Structuring the event
- ◆ Group Support
- ◆ Stress Education

A Case Example

- ◆ Cerritos
- ◆ Total Killed 82
- ◆ Survivors 0
- ◆ Homes 16
- ◆ Civilians 15
- ◆ Res Pers 300
- ◆ Body Parts 10000
- ◆ San Diego
- ◆ Total Killed 125
- ◆ Survivors 0
- ◆ Homes 16
- ◆ Civilians 15
- ◆ Res Pers 300
- ◆ body parts 10000

A Case Example

- ◆ Cerritos
- ◆ 12 Debriefings
- ◆ Many Demobilizations
- ◆ Hot-line
- ◆ Follow-up
- ◆ San Diego
- ◆ Sporadic on-scene intervention

A Case Example

- ◆ Cerritos
- ◆ One Loss
- ◆ Increase in MH 01%
- ◆ San Diego
- ◆ Loss of Police 5
- ◆ Loss of Fire 7
- ◆ Loss of Paras 17
- ◆ Increase in MH 31%

SPRINT

- ◆ Special Psychiatric Rapid Intervention Team
- ◆ Official Sites: San Diego, Portsmouth, Bethesda, Oakland
- ◆ West Coast 619-532-8551
- ◆ East Coast 757-953-5281
- ◆ BUMED CODE-311

What to do

- ◆ Acknowledge the Problem
- ◆ Assess Magnitude, personal, group
- ◆ Assess Local Assets/ Chaplains etc...
- ◆ Sell to command
- ◆ QUICKLY, organize CISD with local assets or Activate Sprint
- ◆ Follow-up

CRITICAL INCIDENT STRESS INFORMATION SHEETS

You have experienced a traumatic event or a critical incident (any incident that causes emergency service personnel to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very common, in fact quite *normal*, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks or a few months and occasionally longer depending on the severity of the traumatic event. With understanding and the support of loved ones the stress reactions usually pass more quickly. Occasionally, the traumatic event is so painful that professional assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by themselves.

Here are some common signs and signals of a stress reaction:

<i>Physical*</i>	<i>Cognitive</i>	<i>Emotional</i>	<i>Behavioral</i>
chills	confusion	fear	withdrawal
thirst	nightmares	guilt	antisocial acts
fatigue	uncertainty	grief	inability to rest
nausea	hypervigilance	panic	intensified pacing
fainting	suspiciousness	denial	erratic movements
twitches	intrusive images	anxiety	change in social activity
vomiting	blaming someone	agitation	change in speech patterns
dizziness	poor problem solving	irritability	loss or increase of appetite
weakness	poor abstract thinking	depression	hyperalert to environment
chest pain	poor attention/ decisions	intense anger	increased alcohol consumption
headaches	poor concentration/memory	apprehension	change in usual communications
elevated BP	disorientation of time, place or person	emotional shock	etc...
rapid heart rate	difficulty identifying objects or people	emotional outbursts	
muscle tremors	heightened or lowered alertness	feeling overwhelmed	
shock symptoms	increased or decreased awareness of surroundings	loss of emotional control	
grinding of teeth		inappropriate emotional response	
visual difficulties		etc...	
profuse sweating			
difficulty breathing			
etc...			

* Any of these symptoms may indicate the need for medical evaluation.
When in doubt, contact a physician.

THINGS TO TRY:

- WITHIN THE FIRST 24 - 48 HOURS periods of appropriate physical exercise, alternated with relaxation will alleviate some of the physical reactions.
- Structure your time - keep busy.
- You're normal and having normal reactions - don't label yourself crazy.
- Talk to people - talk is the most healing medicine.
- Be aware of *numbing* the pain with overuse of drugs or alcohol, you don't need to complicate this with a substance abuse problem.
- Reach out - people do care.
- Maintain as normal a schedule as possible.
- Spend time with others.
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing.
- Give yourself permission to feel rotten and share your feelings with others.
- Keep a journal, write your way through those sleepless hours.
- Do things that feel good to you.
- Realize those around you are under stress.
- Don't make any big life changes.
- Do make as many daily decisions as possible which will give you a feeling of control over your life, i.e., if someone asks you what you want to eat - answer them even if you're not sure.
- Get plenty of rest.
- Reoccurring thoughts, dreams or flashbacks are normal - don't try to fight them - they'll decrease over time and become less painful.
- Eat well-balanced and regular meals (even if you don't feel like it).

FOR FAMILY MEMBERS & FRIENDS

- Listen carefully.
- Spend time with the traumatized person.
- Offer your assistance and a listening ear if they have not asked for help.
- Reassure them that they are safe.
- Help them with everyday tasks like cleaning, cooking, caring for the family, minding children.
- Give them some private time.
- Don't take their anger or other feelings personally.
- Don't tell them that they are "lucky it wasn't worse" - traumatized people are not consoled by those statements. Instead, tell them that you are sorry such an event has occurred and you want to understand and assist them.

CHAPTER SIXTEEN

Medico-legal Issues

In Clinical Practice

An Overview

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999/2000

Terminal Objectives

At the completion of this lecture the student will:

- learn the background and origin of the legal focus in medical practice,
- understand the major legal/ethical issues in the primary care setting
- Have a set of tools to deal with potentially difficult cases effectively and efficiently
- AND.

Leave this presentation with an open mind towards why we must do certain things:

CONSIDER

Perhaps you are doing something because it is the right thing for the patient

rather than

"because some S%&# lawyer told me to!!!"

Enabling Objectives

- Briefly discuss why medical malpractice litigation has increased in the last 30 years
- State the four legs of a negligence suit
- Provide two examples of potential liability from clinical practice
- Provide two nonclinical examples of potential negligence actions
- Discuss why patients sue

The Origins of Change

- Social Issues of the 1950's-60's-70's:
 - Civil Rights Movement, Women's Movement, Vietnam Protest, Human Rights, Consumer Rights, etc..
- Parallel emergence of medical ethics
- Principles derived from the Hippocratic Oath
 - Primary principle: **autonomy** (the right of each person to decide what is best for them)

Medical Ethics

- Second Principle: **beneficence** (do what is right)

• best known as nonmaleficance - **DO NO HARM**

- Autonomy and beneficence are defined from the patient's standard - **NOT** ours as their physician - in the past **we** would decide what was best for the patient, explain it to them, and proceed.

Social Changes

- All of the social issues revolved around the basic constitutional rights of individuals
- As laws were enacted and upheld there became an increase in the number of civil suits by individuals against individuals, organizations, and the government
- Thus, there also was an increase in medical malpractice litigation

Development of Malpractice

- Until the 1960's the medical malpractice suits that occurred were the egregious ones that generally fell under the category of "**Res Ipsa Loquitor**"
- **Let the thing speak for itself** - the cases where no expert witness is needed
- the test is whether you say "*Oh my God!!!*" when you hear the story

SCOPE of PROBLEM

(not as bad as you might think)

- 1% of hospital admissions found to have negligence (consistent over time)
- only 1/20 of these cases actually result in any formal legal action
- although you may have seen articles decrying the huge settlements and increasing payments, these can be misleading - there are both increases in arbitration and tort reform

This preface is *not* to let the lawyers off free and easy however -

- but first a very quick and dirty overview of malpractice law.

Why cover this boring subject at all? Aren't we free from malpractice concerns in the military?

- No
- And Yes. . . .

Federal Tort Claims Act

- Created a **waiver of sovereign immunity**
- Federal Law passed in 1945 to allow individuals to submit a claim for negligent acts by government employees acting in the scope of employment

Feres Doctrine

- Three 1950 cases heard by Supreme Court (two of them medical malpractice)
 - the outcome was a statement that the FTCA was a very limited waiver of sovereign immunity and did NOT apply to military members (considered fair because of the other mechanisms of compensation - medical care and disability)

Limited Personal Liability

- Gonzales Act (applies only to health-care providers) and
- Federal Employees Liability Compensation Act (applies to all government employees)

Provides a mechanism to protect Federal employees from personal financial liability

The remedy for negligence is against the government, NOT the individual

Representation by DOJ

- Current and Former Government Employees May Seek Substitution or Representation by the Justice Department when Sued in their Official Capacity

HELP!!



What Happens in the Military

- **VARIABLE**
- currently being addressed due to the 1997 Akron, Ohio newspaper article addressing the problems with military medicine
- The goal is to meet the reporting standard. AT BUMED/OSD(HA) at this moment...

National Practitioner Data Bank

- Created by the Health Care Quality Improvement Act of 1988
- Any physician's name is to be submitted if there is a settlement against them, adverse privileging action, or action from their state board.
- Meant to prevent physicians practicing substandard medicine from state-hopping
- A hospital **MUST** query the NPDB before credentialing a physician; other *may*

- Proposal is that only in those cases where there is a settlement *due to negligence* will the names be reported to the NPDB.
- What about in negligence to military members?
 - Individual is compensated through disability and physician behavior is addressed through RM programs/credentialing actions/etc

- ### Malpractice 101
- TORT LAW covers civil actions between two parties
 - *intentional torts* (e.g., assault & battery, sex with patients, false imprisonment) are deliberate actions which may cause damage - usually not covered by malpractice insurance
 - *unintentional torts* including **NEGLIGENCE** (*behavior that possesses an unreasonable risk of causing harm*)

Malpractice 101 (cont.)

Medical malpractice is one type of the broader area of negligence law

- ### Principles of Negligence Law “The 4D’s”
- DUTY
 - DERELICTION of DUTY
 - DIRECT CAUSATION
 - DAMAGES
- Without these four elements a proposed negligence action cannot stand

DUTY

Once a professional relationship is established, every physician has an obligation to provide adequate care to the patient (practice the S-O-C)

Standard of Care for Physicians Florida Law

A physician must act with that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health-care providers

A national, not a local standard.

DERELICTION

A **deviation from the standard of care** (derived from specialty guidelines, JCAHO, hospital policy, etc..)

[example: beta blockers post MI]

As a **direct** result (proximate cause) of that deviation from the standard of care (**dereliction of duty**), **damage** occur.

- DUTY
- DERELICTION of DUTY
- DIRECT CAUSATION
- DAMAGE

DAMAGE = **INJURY**

(Damages also refers to \$\$\$\$)

Types of DAMAGES

- **Actual, or economic** - financial remuneration for expenses **directly** related to the injury (medical bills, lost wages)
- **Noneconomic, or compensatory** - for pain and suffering - several states have a cap on this amount
- **Punitive** - to punish the defendant

Doctors are expected to be **adequate**, not perfect

Care must be **acceptable** and **appropriate**, not exceptional

Every bad outcome does **NOT** imply negligence

WHY DO PATIENTS SUE?

For a patient or family to consider a malpractice suit they generally experience two things:

- A bad outcome
- And bad feelings

SPECIFIC ISSUES

- Informed Consent
- Confidentiality (Privilege)
- Right to refuse treatment
- End of life issues
- Termination of Treatment (Abandonment)
- Duty to disclose errors
- Good Samaritan Actions
- Physician/Patient Sex
- Physician-Assisted Suicide

In military cases, federal law governs procedural issues whereas state law governs most substantive issues (e.g. emotional recovery in malpractice)

Where there is federal law that sets a higher standard of care than state law the federal law takes precedence (e.g. 1999 SECNAV 6320.24A)

"If you turn a map of the United States sideways, everything loose rolls to California. . ."

H. L. Mencken

Informed Consent

- Several IC cases in the 60-70's were some of the first "non-clinical" malpractice cases
- Natanson v. Kline (1960)
 - 1st informed consent case
 - no informed consent
 - established the reasonable medical practitioner standard

Informed Consent (cont.)

- Canterbury v. Spence (1972)
 - risks not explained to pt
 - established "materiality of the information standard" - what would any reasonable person want to know to make the decision
- Truman v. Thomas (1980)
 - risks of not having treatment not explained
 - established the need to provide the risks of no treatment

■ Informed consent is a legal and ethical doctrine that requires health care professionals to inform their clients about their assessment of the client's problems and the risks and benefits of various treatment options.

■ Assessment or treatment of individuals without informed consent constitutes malpractice except where the law presumes consent (e.g., in an emergency, therapeutic privilege, therapeutic waiver)

■ *any nonconsensual touching = BATTERY*

Informed Consent

A ***DIALOGUE*** between the clinician and the patient:

NOT a signature on a piece of paper

■ **A SHARING OF UNCERTAINTY** in the decision-making process that strengthens the doctor/patient relationship (and, if done right, transfers responsibility from doctor to patient)

(and goes a ***LONG*** way toward ensuring it doesn't become a doctor/*plaintiff* relationship)

■ Informed consent is a ***PROCESS*** that begins at the first meeting and continues throughout the relationship

Components of Informed Consent

THE PATIENT MUST HAVE:

- Understanding of the *diagnosis and prognosis*
- Understanding of the *risks and benefits (and costs) of the proposed treatment*
- Understanding of the *risks and benefits (and costs) of alternative treatments*
- Understanding of the *risks, benefits, and prognosis of no treatment*

(IC implies competence)

Florida Medical Consent Statute

- On *surface* seems to obviate requirement for IC
- BUT. . . . ensuring informed consent is the **standard of care**
- Index of concern for good documentation of IC (and capacity!) increases in cases where someone *refuses a tx with low risk/high benefit* or *agrees to tx with high risk/low benefit*

One of the best things you can do is to ask your patient about his or her expectations:

"What does success mean to you in this case?", or
"What do you hope to get from the treatment?"

This will help differentiate what you think success is from what the patient envisions
- these may be two very different goals

Economic Informed Consent

- A new concept in **managed care**
 - If, from day one, you are honest with the patient about what their coverage includes*, you can plan with the patient and their family for eventualities
 - you are removed from the role of messenger bearing bad news
- this strengthens the alliance
- *many states now have statutes making gag clauses for physicians illegal

CONFIDENTIALITY

It is the **Clinician's Obligation** to keep material shared in a professional relationship from third parties unless permitted. This is an ethical and legal requirement.

PRIVILEGE

The **Patient's Right** to bar the clinician from testifying about professionally-obtained material in judicial-like settings.

Exceptions to Confidentiality

- Emergencies (including Tarasoff warnings)
- Dual Agency (military, prisons, schools)
- Mandatory Reporting (abuse, communicable diseases, etc.)
- court-ordered exams
- patient/litigant

CAVEATS in Confidentiality

- Know your local procedures for release of information - if in doubt, ask - *don't* assume
- Be careful what is said in casual conversation (or left laying around)
- HIV, Dept of Motor Vehicles (DMV: 850-488-8982)
- From a famous defense counsel: *"I would much prefer to defend a breach of confidentiality case than a wrongful death case."*

Right to Refuse Treatment

- Follows reasoning of informed consent process
- Under medical model competent patients have the right to refuse various types of treatment - including life-saving treatment
- Justice Cardoza, 1914: *"Every human of adult years and sound mind has a right to determine what shall be done to his own body."*

In the Incompetent Committed Pt

- Two models:
 - *Treatment Driven*: based on professional judgment
 - *Rights Driven*: substituted judgment
- Federal - professional judgment
- States - varied:
 - NJ: 2nd doctor
 - Mass (OK, NY, CO, WI) judicial
 - Utah: presumed incompetent upon commitment

Patient signs out "AMA"

- Unless required, do *not* use "AMA" form: these are adversarial, only documents the pt was aware you didn't want them to leave
- A progress note is *always* better: documents your and the pt's reasoning and is not adversarial - allows dialogue
- Ensure pt knows where they can go for follow-up and what symptoms to be concerned about

End of Life Issues

- Following 1990 Patient Self Determination Act all hospitals must offer pts advanced directives
- Should be part of the ongoing informed consent process - not put off until pt in extremis
- Also involve family if patient agrees
- Review hospital "no code" policy
- If in doubt, involve hospital ethics committee

Physician-Assisted Suicide

- Two 1997 Supreme Court cases: challenged state law banning PAS based on 14th amendment
- Both overturned - Supreme Court supported state laws
- But will not challenge state with law supporting PAS
- Effect of these issues have improved diagnosis/tx of pain and depression

Good Samaritan Laws

- In place to encourage physicians to assist in emergencies
- there is no duty to do so however
- Good Samaritan Law even covered a physician responding to a cardiac arrest in a hospital (when that physician had no duty to that patient)
- 1998 Aviation Medical Assistance Act

ABANDONMENT

- Once you have a duty to a patient are you umbilically connected forever? **NO!**
- Termination of treatment is **NOT** abandonment unless termination occurs during an emergency or without offering the patient alternative arrangements
- Several instances of appropriate termination: noncompliance with the treatment plan, abusiveness, sexual advances, etc.

PHYSICIAN/PATIENT SEX

- Don't. . . . *Ever*
- 80% of docs are attracted to a pt; 20% consider sex; 18% of OB-GYN, 10% of primary care, 5% of psychiatrists have had sex with at least one patient
- profile:
 - male, 40's-50's, troubled marriage, burned out/depressed, alcohol abuse

Physician/Pt Sex (cont.)

- criminalization for psychiatrists
- a felony in four (+) states (MN, WI, CO, SD)
- MN has mandatory reporting
- ALWAYS an ethical violation
- frequently the plaintiff doesn't sue for sex (an intentional tort not covered by malpractice) but for "mishandling the transference"
- As FPs assume more psychiatric tx of pts there will be a higher standard applied

Given the many factors in the physician-patient relationship that skew the equality, a patient can never truly give informed consent for sex.

- Recent state laws reflect the perception that sexual involvement with a health care provider is akin to childhood incest perpetrated by a parent.
- Common to both situations is that a trusted authority figure engages in exploitative sexual contact with someone in a vulnerable, dependent position

- ### CLINICAL GUIDELINES
- Generally very positive
 - Do not create overelaborate ones - if the organization uses them you must also
 - Used for defense and plaintiff
 - Many cases where guidelines are used never reach the status of a formal suit

- ### Pearls for Litigation Avoidance
- First and foremost - establish the alliance (communication)
 - **Documentation** - write smarter, not more; never "fudge" a record; all changes transparent and explained (better to write later note); no emotional diatribe in chart; no ambiguous sentences
- ASSESSMENT/RESPONSE**

- ### Pearls (cont.)
- **Consultation** - a win-win
 - anonymous case discussions reap benefits without putting colleague at risk
 - demonstrates you are a provider who seeks opinions other than your own
 - **Don't Make Promises** - there is no such thing in medicine
 - sets you up for a "breach of contract" suit

- ### Tools for:
- the high risk patient
 - the high risk family
 - the high risk provider
 - the high risk situation

- ### The High Risk Patient
- RULE OF THIRDS
 - The Hypochondriacal Patient
 - their suffering needs to be heard
 - fear abandonment
 - Patient with prior trauma
 - if a bad outcome/pain the pt may project earlier anger onto you
 - Narcissistic Patient
 - will blame doctor for the imperfection

High Risk Patient (cont.)

■ The Litigious Patient

- take a legal history ("Do you have any stressors? Financial, legal, work, etc?")
- If a history of disability at increased risk

■ The Doctor-Shopper

- particularly in chronic illness

The High Risk Family

■ Caretakers of someone with a chronic disease

- at death family may be drained of resources and have a sense of relief
- they then feel guilty and may project that feeling onto physician

■ Caretakers of an abusive patient

- project anger for the abuse they have endured onto the physician
- may even blame physician for keeping pt alive

High Risk Family (cont.)

■ Families of patients with somatoform disorder

- a failure to diagnose the 1000th headache as the subdural haematoma. . .

■ Families who have experienced medically related deaths or bad outcomes

- may desire current compensation for an uncompensated earlier loss

Ask:

"Have you, or anyone in your family, had a bad experience with medical care or doctors?"

This information can provide you with insight into how the patient will frame future experiences

High-Risk Physician

■ Physician as God

■ Physician as technician

- medical record becomes more important than the patient

■ Guilt-ridden physician

■ Defensive Physician

- never admits to a mistake

Duty (ethical) to Disclose Errors

■ Most patients want to know

■ A large % of plaintiffs stated that what they really wanted was an apology and acknowledgment of their suffering

■ Usually a mistake is an error of judgment, not an error of fact which is not actionable

■ Massachusetts has an "apology statute"

■ **CAVEAT** - be careful when broaching this subject - always OK to empathize with suffering, but be judicious (unless in private practice in Massachusetts).

High-Risk Situation

- 1st encounter occurs under stress (ER)
- No ongoing care - serious of encounters with different doctors
- Informed consent is only pro forma - no attempt to reach a true understanding
- No attempt made to assess decision-making competence
- No attempt made to involve family
- Managed care

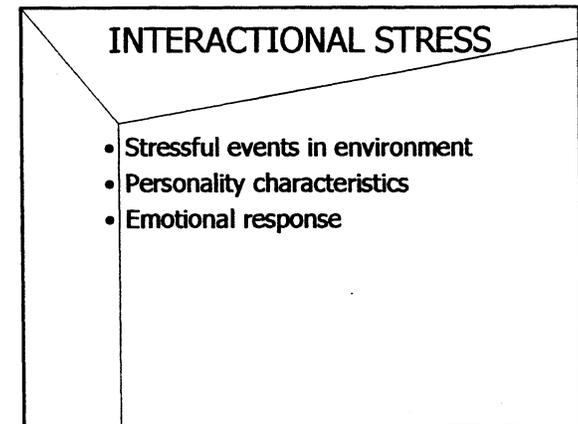
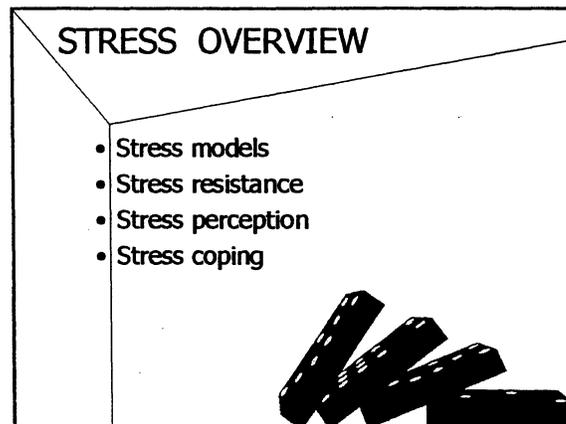
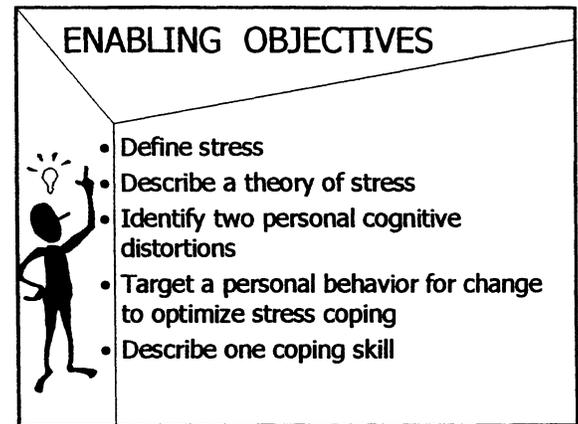
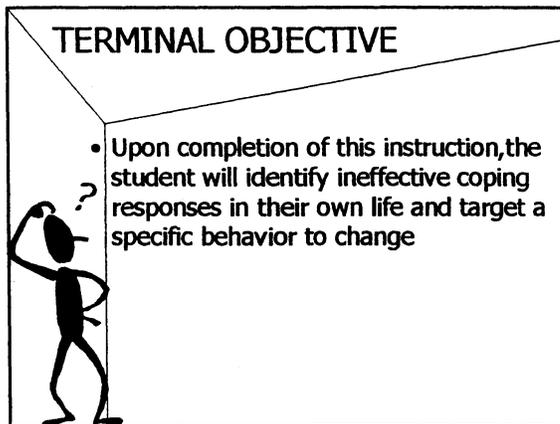
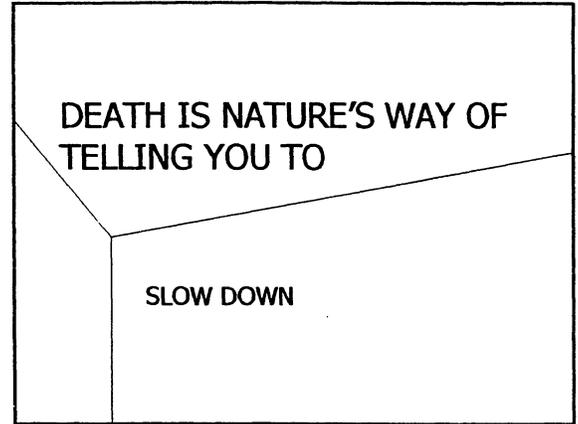
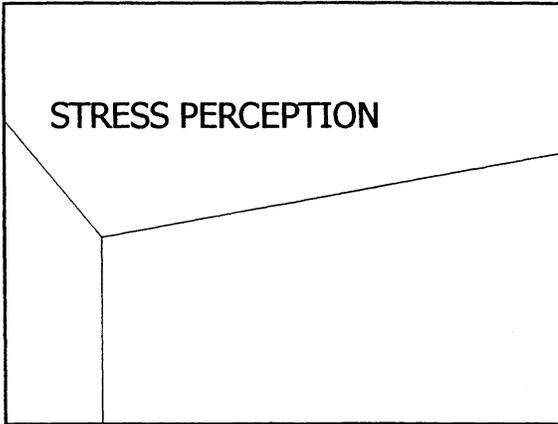
Remember the concept of sharing uncertainty in the decision making process,

Document the decisions your make,

And consult when appropriate

Any ?'s

CHAPTER SEVENTEEN



OPTIMIZE STRESS IMMUNITY

- Sleep
- Exercise
- Nutrition
- Alcohol limits
- Limits at home
- Limits at work

POWER SLEEP

- Sleep deprivation = disaster
- Identify your need
- Pay your sleep debt

SLEEPY DISASTERS

- Chernobyl
- Three-mile Island
- Exxon Valdez

SLEEP-DEPRIVED MISHAPS

- Failure to extend flaps prior to take-off
- Shut down engine in mid-air
- Landing with wheels up
- Landing at wrong airport
- Premature descent

SIGNS OF SLEEP-DEPRIVATION

- Falls asleep immediately
- Requires alarm clock
- Weight gain under stress
- Lethargy

THE "RIGHT STUFF"

- Get adequate sleep
- Set sleep schedule
- Continuous sleep
- Repay sleep debt

HOW TO GAIN WEIGHT LIKE A SUMA WRESTLER

- Eat one meal per day
- Eat late in the day
- Exercise on an empty stomach
- Workout at a fast pace

SETTING LIMITS

- 2+1+1 rule
- 2 POSITIVE STATEMENTS
- 1 NEGATIVE STATEMENT
- 1 POSITIVE STATEMENT

STRESS PRONE PERSONALITY



- Free- floating hostility
- Self-constraining
- Competitive drive
- Workaholic
- Over plans
- Time urgency
- Accomplishment orientation
- Seeks approval of superiors
- Materialistic

STRESS RESISTANT PERSONALITY

- Change as challenge
- Multidimensional
- Social support system
- Self-confident
- Religious values
- Reflects and rewards

P.O.W. "COPING MODEL"

- Communication
- Physical exercise
- Structure environment
- Sense of purpose

LEARNED OPTIMISM

- Permanence
- Pervasiveness
- Personalization

PERMANENCE

- Bad events are permanent
- Good events won't last

PERVASIVENESS

- Catastrophize
- Compartmentalize

PERSONALIZATION

- Internalize blame
- Externalize circumstances

CHANGE YOUR MIND

- Reframe irrational ideas
- Interrupt patterns
- Visualize success

IF YOU CAN'T FIGHT
AND
YOU CAN'T FLEE



FLOW

SUMMARY

- Stress definition and theory
- Cognitive distortions
- Examined personal behavior
- Target behavior for change
- Coping strategies

CHAPTER EIGHTEEN

Malingering

D.J. Wear-Finkle, MD, MPA
CAPT, MC, USN
NOMI - 1999/2000

Terminal Objective

At the completion of this lecture the student will have an understanding of malingering, when to keep malingering in the differential diagnosis, and what to do if clearly confronted by malingering

Enabling Objectives

- State the definition of malingering
- Differentiate malingering from similarly presenting disorders
- Discuss the role of the flight surgeon in making recommendations for disposition

MALINGERING

The intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.

Examples of Incentives

- avoiding work
- obtaining financial compensation
- avoiding military duty
- evading criminal prosecution
- obtaining drugs
- *may be adaptive (POW)*

Malingering vs. Factitious Disorder

In malingering, the motivation for symptom production is an external incentive whereas in factitious disorder the external incentive is absent. In factitious disorder, there is a need to maintain the sick role. This is also known as Munchausen's Disease.

Malingering vs Other

What differentiates malingering from Conversion Disorder and other Somatoform Disorders is the *intentional* production of symptoms.

Great Malingerers

- Historic Soldier
- (see film clip)

Simulation:
"faking bad"

Dissimulation:
"faking good"

Suspect Malingering if:

- Medicolegal context (referred by an attorney)
- Marked discrepancy between the person's claimed stress or disability and the objective findings
- Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment
- The presence of Antisocial PD

Your Role

- Be aware of your own feelings (angry, betrayed)
- Don't Rx with drugs for vague complaints
- It is *NOT* your job to diagnose malingering: You can always state something like: "*I am unable to find a clear underlying physiologic cause for the symptoms. . .*" or, "*I cannot find objective substantiation for the stated symptoms . . .*"

The specialist is usually the person to diagnose malingering - and then it is difficult to prove (unless the patient admits it)

APPENDIX A



Stress Management

CDR Mark Mittauer

Enabling Objectives

- ✦ Identify causes of stress
- ✦ Discuss the harmful effects of stress
- ✦ Discuss how to eliminate avoidable sources of stress
- ✦ Discuss how to adjust to unavoidable sources of stress



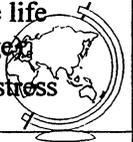
Enabling Objectives (cont.)

- ✦ Discuss techniques for improving assertiveness
- ✦ Discuss techniques for better anger management
- ✦ Describe and practice three stress management exercises



Causes of Stress

- ✦ What are sources of stress in your life?
- ✦ Stress may result from daily hassles
- ✦ Stress may result from major life events
- ✦ Stress may result from welcome life events (e.g., promotion, marriage)
- ✦ CHANGE is a major source of stress



Harmful Effects of Stress

- ✦ Illness - infections, cancer progression, high blood pressure, obesity from overeating, heart disease, ulcers
- ✦ Fatigue - that may lead to mistakes and injury or death



Useful Stress

- ✦ Stress can be helpful when it motivates us to accomplish a task *now!*



Symptoms of Stress

- ✦ Physical
- ✦ Emotional
- ✦ Cognitive
- ✦ Behavioral



Physical Symptoms of Stress

- ✦ muscle tension
- ✦ headache
- ✦ fatigue
- ✦ sleep problems
- ✦ gastrointestinal problems
- ✦ high blood pressure



Emotional Symptoms of Stress

- ✦ irritability
- ✦ arguing
- ✦ anxiety
- ✦ depression
- ✦ lack of enjoyment
- ✦ mood swings
- ✦ suicidal thoughts
- ✦ homicidal thoughts



Cognitive Symptoms of Stress

- ✦ inattention
- ✦ distractibility
- ✦ forgetfulness
- ✦ confusion
- ✦ poor concentration



Behavioral Symptoms of Stress

- ✦ social isolation
- ✦ work problems
- ✦ conflicts with coworkers, friends, and loved ones
- ✦ unhealthy habits - overeating, alcohol misuse, nicotine use, caffeine misuse, workaholism
- ✦ aviator: conflicts with peers, disregarding rules and checklists



Better Stress Coping

- ✦ Eliminate avoidable causes of stress
- ✦ Handle unavoidable causes of stress more effectively



Avoidable Causes of Stress

- ✦ Nicotine
- ✦ Alcohol
- ✦ Overeating
- ✦ Caffeine
- ✦ Sleep problems



Nicotine

- ✦ Chewing tobacco (“dip”) can cause mouth or lip cancer
- ✦ Exhaled “secondhand” smoke can cause lung cancer, heart disease, and respiratory infections in nonsmoking bystanders
- ✦ Smokers miss twice as much work as nonsmokers due to illness



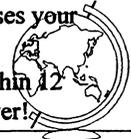
Nicotine (cont.)

- ✦ The medical effects of nicotine use should be well known
- ✦ Children exposed to smoke develop colds, ear infections, asthma, bronchitis, and pneumonia
- ✦ To stop smoking - talk to a medical department representative about smoking cessation classes and nicotine replacement products



Alcohol

- ✦ Medical problems from alcoholism - depression, liver disease, ulcers, high blood pressure
- ✦ Almost one half of sailors who suicide are drunk
- ✦ A blood alcohol level of .15 increases your chance of a car wreck 24 times
- ✦ NATOPS 3710.7Q: no alcohol within 12 hours of flight planning; no hangover!



Alcohol (cont.)

- ✦ Drinking only two drinks at bedtime causes less restful sleep - leading to fatigue the next day
- ✦ If you drink too much - talk to your command DAPA or medical department representative, or visit Alcoholics Anonymous (AA)



Overeating

- ✦ Medical problems from overeating - obesity, high blood pressure, diabetes, heart disease, stroke, high lipid levels
- ✦ Strict dieting or fasting does not result in sustained weight loss - your metabolism slows and you regain weight when you resume “normal” eating
- ✦ Overeaters’ Anonymous may help



Overeating (cont.)

- ✦ Commercial weight reduction programs and diets are costly and no more effective
- ✦ Eat three meals a day - to avoid evening binges
- ✦ Select a high fiber, low fat diet
- ✦ Cut calories by using sugar substitutes, sugar-free sodas, fat-free salad dressing, and skim milk; avoid gravy, deserts
- ✦ Healthy snacks - carrots, celery, pickles, lettuce, fruit



Caffeine

- ✦ Caffeine increases your alertness for several hours - but then causes increased fatigue
- ✦ Health problems from caffeine use - high blood pressure, anxiety, irritability, withdrawal headaches, sleep problems
- ✦ Insomnia may result from any caffeine use after noon
- ✦ Mountain Dew, chocolate, and tea have caffeine



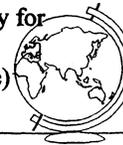
Caffeine (cont.)

- ✦ Decrease your caffeine intake to two or less cups of coffee (or the equivalent) per day
- ✦ Decrease your caffeine use by eliminating one cup of coffee from your daily intake every few days



Sleep Problems

- ✦ 80% of Americans do not get enough sleep
- ✦ Poor sleep causes fatigue, irritability, depression, work inefficiency, and accidents
- ✦ Optimal sleep - 8 to 8.5 hours per night (need minimum of 5 hours to avoid performance difficulties - especially for sedentary persons making complex decisions or needing to be attentive)



More Sleep Facts:

- ✦ Causes of fatigue:
 - 1) sleep debt
 - 2) circadian rhythm disruption
 - 3) prolonged effort (mental, physical)
- ✦ Myths about sleep:
 - 1) cannot "bank" sleep
 - 2) wakeful rest does not replace sleep



Even More Sleep Facts:

- ✦ Symptoms of sleep deprivation:
 - 1) hallucinations (REM intrudes into day)
 - 2) excessive yawning
 - 3) impaired concentration and memory
 - 4) head bobbing (due to "microsleep")
- ✦ Remedy for sleep deprivation:
 - 1) caffeine
 - 2) naps for 60 minutes max (if longer, allow 20 minutes to reach alert state)



How to Improve Sleep

- ✦ avoid heavy exercise and alcohol before bed
- ✦ avoid caffeine use after noon
- ✦ go to bed and awaken at the same time
- ✦ if unable to fall in 30 minutes, arise and read until you feel sleepy
- ✦ avoid naps longer than 30 - 60 minutes
- ✦ relax for 30 to 60 minutes before bedtime
- ✦ relaxation techniques may induce sleep
- ✦ do not check your alarm clock during night



How to Approach Unavoidable Stress

- ✦ Try specific stress management techniques discussed later
- ✦ Change your outlook on how you view stress



Specific Stress Management Techniques

- ✦ Talk to someone (friend, chaplain, mentor, Family Service Center counselor, flight surgeon)
- ✦ Create a support network of friends
- ✦ Schedule fun activities - noncompetitive hobby, reading, music, sightseeing
- ✦ Schedule down time when you have no other activities planned
- ✦ Introduce spirituality into your life



Specific Techniques (cont.)

- ✦ Volunteer to help someone - your life will feel meaningful
- ✦ Aerobic Exercise (biking, running, walking, swimming, aerobics) at least 30 minutes three times a week - improves mood and mental alertness and relieves tension
- ✦ Unclutter your brain - keep an appointment book; write down tasks and prioritize them
- ✦ Allow extra time (arise 10 minutes earlier)



Improve Time Management

- ✦ review your calendar and list of tasks daily
- ✦ prioritize your tasks
- ✦ tackle difficult or irksome tasks first
- ✦ have an agenda for meetings - develop time limits for each agenda item
- ✦ avoid taking office work home
- ✦ work efficiently - you do not have to complete all tasks perfectly
- ✦ make a "plan of attack" and set milestones



Reduce Job Stress

- ✦ Remember that your job is important (hull technician example)
- ✦ Be cheerful - the world will not end if you are grim and serious all the time!
- ✦ Praise your coworkers often - with formal and informal awards
- ✦ Take "fun breaks" at work - talk to someone or review pictures of momentos of fun times



Reduce Job Stress (cont.)

- ✦ Divide the work day into "time chunks"
- ✦ Plan a fun activity after work
- ✦ Delegate work to others
- ✦ If you fall behind, request help and inform your supervisor
- ✦ Set limits on what you are asked to do
- ✦ Establish realistic goals
- ✦ If you feel overwhelmed, do something!



Change Your Outlook on Stress

- ✦ When you feel stressed - take a break, breathe slowly, walk around
- ✦ View life as a challenge or opportunity to excel - and not as a crisis
- ✦ When something goes wrong - think of three ways the situation could be worse
- ✦ Live life "one day at a time" - do not dwell on past mistakes, worry about the future, or wait (miserably) for future happiness



Change Your Outlook (cont.)

- ✦ Learn to enjoy the simple pleasures of life
- ✦ Do not wait for others to make you happy (maintain an internal locus of control)
- ✦ You cannot control how you feel - but you can control what you do with those feelings and how long you keep them (example: when you are angry, do something fun after 30 minutes)
- ✦ Find the positive part of every situation



Change Your Outlook (cont.)

- ✦ Stop wasting time worrying - develop a plan to approach the problem and do something
- ✦ Be prepared to wait - carry book to read, a portable cassette player, or hobby materials
- ✦ Be wary of "the grass is always greener" syndrome before you leave your current situation
- ✦ Always have a back-up plan
- ✦ Decide now what is really important



Faulty Thinking Causes Stress

- ✦ **Catastrophizing** - anticipating a terrible outcome; overexaggerating the importance of a situation
- ✦ **"I can't stand it"** - deciding that you cannot handle a situation, without trying
- alternative: "I can handle this!"
- ✦ **"Should" statements**
e.g. "I should always be happy"
- alternative: "I'm human. I am allowed to make a mistake or have a bad day."



Faulty Thinking (cont.)

- ✦ "Beating yourself up" about past mistakes that you cannot change
- ✦ Worrying about situations over which you have no control, or cannot change
e.g., "If only I had 20/20 vision"
- ✦ **Overgeneralizing** - viewing one negative event as predicting a never-ending pattern of defeat
e.g., "My girlfriend dumped me. I will never date again!"



Faulty Thinking (cont.)

- ✦ **Emotional reasoning** - thinking, "I feel it, so it must be true."
e.g., "I am anxious today, so something terrible will happen!"
- ✦ **Personalizing** - blaming yourself for something that is not your fault
- ✦ **Fairness fallacy** - becoming angry when something disappoints you because you think, "life is supposed to be fair!"



How to Correct Faulty Thinking

- ✦ Recognize your faulty thought patterns
- ✦ Replace irrational ideas with more accurate and realistic ideas



Anger Management

- ✦ You can choose to control how you express your anger (others won't respect you if you curse, yell, or use violence - and you are too important to let situations control you)
- ✦ Speak calmly when disagreeing
- ✦ If you are about to lose control - count to "10" slowly, breathe deeply, and walk away if necessary



Anger Management (cont.)

- ✦ Set limits on how long you choose to be angry - then do something nice for yourself
- ✦ When you disagree with someone, stick to the present issue (and avoid dredging up past hurts)
- ✦ Criticize someone's behavior, not their character



Assertiveness/Better Communication

- ✦ Ask for what you desire
- ✦ Refuse a "tasker" if you do not really want to do it, or if you lack the time to do it well
- ✦ When you make a request, give a reason
- ✦ Be specific with your request (tell the receiver exactly what you want done)
- ✦ Be a good listener - give your full attention, show interest, and summarize what you heard



Relaxation Techniques

- ✦ Slow deep breathing
- ✦ Progressive muscle relaxation
- ✦ Guided imagery



Slow Deep Breathing

- ✦ Inhale slowly through your mouth or nose for 5 seconds, while allowing your stomach to push out
- ✦ Without pausing, exhale slowly for 5 seconds, and tell yourself to relax
- ✦ Perform this techniques for at least 5 minutes whenever you feel stressed, angry, anxious, overwhelmed, or unable to sleep



Progressive Muscle Relaxation

- ✦ Sit in a comfortable chair or lie down
- ✦ Practice slow deep breathing for several minutes
- ✦ Then, tighten and relax each major muscle group in turn (you may choose to relax each muscle group twice)



Guided Imagery

- ✦ Practice slow deep breathing for several minutes
- ✦ Then, practice progressive muscle relaxation
- ✦ Finally, imagine yourself in a pleasant, relaxing setting (example, the beach)
- ✦ Use all of your senses to observe your surroundings



Any Questions?



Finis



STRESS MANAGEMENT EDUCATION

I. NAMI PSYCHIATRY STRESS MANAGEMENT COURSE

At NAMI we have designed a Stress Management Course that reviews the following areas :

- A. **Definition of Stress:** a non-specific response of the body to all non-specific demands, eg. when our competence is challenged or we are struggling to meet unrealistic demands.
- B. **Definition of Stressors:** the factors in our lives that induce the stress response, eg. death of a spouse, marriage or separation.
- C. **Symptoms of Stress:** Physical, Cognitive, Behavioral and Psychological.
- D. **Personality Patterns associated with Stress:** eg. type A and compulsive personality traits...
- E. **Diseases caused or aggravated by Stress include:** alopecia, angina, arrhythmia, asthma, anxiety, acne, arthritis, back pain, back strain, blepharospasm, bruxism, chest pain, carpal tunnel syndrome, constipation, colitis, causalgia, depression, diabetes, diarrhea, duodenal ulcers, dysphagia, dermatitis, dysmenorrhea, dizziness, dyspnea, migraine headaches, tension headaches, Raynaud's syndrome and a myriad of others.
- F. How to cope with stress by learning better sleep hygiene, learning proper time management techniques, learning how to avoid procrastination, and learning how to develop an interpersonal and social support system.
- G. Assertiveness training teaches individuals to make their wants and desires known in an acceptable manner.
- H. Breathing techniques include diaphragmatic, clavicular and abdominal breathing instruction and practice.
- I. Nutrition and exercise are discussed to emphasize the need for a balanced diet free of saturated fats, cholesterol, too much salt and sugar. The need for fiber and white meat are discussed. The need for a balanced exercise program is emphasized during the course of study. Individuals are encouraged to establish a routine that they can follow daily with at least one hour of exercise included.

J. Over the counter medications, caffeine and nicotine are discouraged.

II. STRESS MANAGEMENT COURSE CURRICULUM

The course is conducted over five successive days in two hour sessions each day by the Stress Management Educator. Referrals are accepted from the Flight Surgeon for stress management on a SF-513. A Psychiatric History Questionnaire and an MMPI for enlisted or a NEO-PI for officers are administered. After evaluation of these instruments if no significant psychopathology is discovered the individual is admitted to the class. If pathology is discovered they are referred to one of the Mental Health Providers. Homework assignments are given and a test upon completion with the graduate being offered a certificate of completion.

DAY I

A. What is stress?

1. Stressors-the factors that cause stress.
2. Stress defined.
3. Not all stress is bad.
4. The human performance curve.
5. Keeping the balance.
6. Positive and negative stress.
7. Who experiences stress?
8. Where and when does stress occur?
9. Understanding stress physiology.
10. Primitive stress response.
11. Stress response pathways.
12. Adaptation to stress.

B. Personality factors or behavior patterns and occupational stressors.

1. Type A behavior patterns, main characteristics and causes.
2. Type B personality characteristics.
3. Personality patterns, migraines, colitis, arthritis.
4. Management of occupational stress:
 - a. Working class
 - b. Stress and the working woman.

C. Domestic, economic, political, and social stressors.

1. Marriage or partnership.
2. Divorce or separation.
3. Children.
4. Economic and political climate.
5. Social and ecological environment.
6. Social class and health.

7. Adjustment to change.
 8. Pollution.
- D. When stressors are likely to cause stress?
1. Stages of life: early childhood, adolescence, early adulthood, midlife and old age.
- E. How to recognize when you are under stress?
1. Early warning signals: cognitive, psychological, physical and behavioral.
 2. Stress and illness: angina, migraines, heart attacks, anxiety, chronic fatigue, depression, phobias, ulcer, burnout, and eventual decompensation.

DAY 2

How to cope with stress

A. Breathing

1. Yoga.
2. Cosmic Breathing.
3. Cellular respiration.
4. Breathing and emotions.
5. The respiratory system.

B. Types of Breathing

1. Costal or chest breathing.
2. Abdominal or diaphragmatic breathing.
3. Clavicular breathing.

C. Breathing and the brain...

D. Abnormal breathing

1. Hyperventilation
2. Sleep apnea.
3. Paradoxical.

E. Breathing exercise.

1. Abdominal-supine or crocodile position.
2. Alternate nostril breathing.
3. One minute breath.
4. One breath-mini relaxation.

F. Physical relaxation

1. Simple relaxation
2. Relaxation training
3. Deep muscle relaxation
4. Time

5. Place
6. Posture
7. Deep muscle relaxation
8. Coming out of relaxation

DAY 3

- A. Integrating relaxation into everyday life.
- B. Progressive muscle relaxation.
- C. Autogenic.
- D. Massage.
- E. Biofeedback.
- F. Mental Relaxation
 1. Meditation
 - a. Devotional path
 - b. Physical path
 - c. Intellectual path
 - d. Commitment
 2. Benefits of meditation and deep muscle relaxation.
 3. Creative visualization.

DAY 4

Developing Communication Skills

- A. Lack of assertiveness
- B. Anger and hostility.
- C. Strategies for improving assertiveness:
 1. Identify the problem area.
 2. Be aware of nonverbal communication.
 3. Change your dialogue.
 4. Be Persistent.
 5. Make a workable compromise.
 6. Assertive social conversation.
 7. Understand your critics.
 8. Respond to critics appropriately.
- D. Strategies for managing anger:
 1. Respond positively to criticism
 2. Help anger simmer down
 3. Use anger creatively
 4. Catharsis
 5. Learn the act of forgiving and how to forgive.

E. Other strategies for managing stress:

1. Be aware of stress- read your body signals.
2. Avoid unnecessary stress.
3. Anticipate stress and be prepared.
4. Strategies for positive anticipation:
 - a. Imagine the forthcoming event.
 - b. Prepare adequately.
 - c. Rehearse the night before
 - d. Plan pleasurable activity
 - e. Prepare for the worst
 - f. Relax before the event
 - g. Expect some stress
 - h. Take time out to recuperate
 - i. Reward yourself
5. Anticipate regular event
6. Stress is not black and white
7. Negative self-talk and positive antidotes
8. Master problem-solving skills
9. Manage time effectively
10. Strategies for time management--delegate tasks
11. Have humor in your life
12. Alter your perspective

DAY 5

Nutrition and a healthy life style

A. Nutrition

1. Saturated fats and cholesterol
2. Vegetarianism
3. Fiber
4. Sugar
5. Salt

B. Maintaining the ideal body weight

1. How to stick to a diet
2. Anorexia and bulimia

C. Smoking

1. Long term effects
2. Rationalization
3. Giving up

D. Alcohol

1. Moderate or heavy drinking
2. Getting help

E. Caffeine

F. Tranquilizers and Sleeping pills

- G. Useful steps to change harmful habits
- H. Physical fitness
- I. Review
- J. Summary
- K. Test

III. GENERAL INFORMATION ABOUT STRESS

Stress is a perception and usually results from our perceived inability to handle a situation. Stress management is a process in which recent advances in the sciences of medicine, psychology, and electronics are combined to produce an effective type of physiological self-control.

In the events of day-to-day life an individual learns bodily responses to combat the threats encountered. Some of these maladaptive responses are destructive to the self and must be unlearned in order to insure a longer, more healthy life.

The very same physiological changes that protected our ancestors from lions and bears by preparing our musculoskeletal, cardiovascular, and sympathetic nervous system for fight or flight, are in our modern society preparing our bodies for heart attack, ulcers, high blood pressure, and chronic pain such as headache.

These maladaptive bodily responses which have been learned can be unlearned. Their potentially damaging effects can be arrested or reversed through biofeedback training.

Sophisticated biofeedback electronic instrumentation can help detect, bring to awareness, and provide feedback for learning to control the bodily system most effected by the stress of daily life and reduce the risk of unhealthy life or early death.

This process of learning combines behavioral psychology techniques such as conditioning, relaxation training, habit-breaking, and self-management, with recent advances in medical research and microcomputer electronics. With these advances we have a way to bring new awareness and understanding to an individual of personal stress responses. We also have tools to train the person to control the negative effects of stress to facilitate the process of recovery from stress.

Typically this process takes a short time. We strive to interrupt the destructive stress response before it is so advanced that medical signs and symptoms are produced making it more difficult to reverse. These stress management techniques and attitudes have been surprisingly effective for many people. When

more stress related illnesses have developed, these lifestyle changes along with behavioral medicine and biofeedback treatment can combine to reverse the process.

People are now more aware of the need to investigate their bad habits, and have taken steps to improve their vitality and life. By eating better foods, getting more exercise, avoiding pollutants, and becoming more aware of interpersonal relationships, some individuals have made significant positive changes in their life-style. Relaxation skills, biofeedback and self-management techniques offer additional ways to improve and complete this process.

A major life skill in our society today is to be able to integrate change and its accompanying stress in a constructive and creative way. Researchers estimate that there has been more cultural, social and economic change in the world in the last 50 years than in the preceding two million years. Thus, the impact of the last five years may be minor compared to the changes we will undergo in the next five years.

An individual can expect to change careers five to seven times during his working lifetime. We have adopted a way of life in which almost everything is temporary and disposable - from razors and pens, to our home geographical locations and even marriages.

Some major changes affecting individuals:

1. Personal value changes- the new ethics; the modern cultural revolution.
2. Knowledge and technology explosion-the requirements to integrate new information at an ever-increasing rate.
3. Distrust, even at high levels-in the government; the media, etc.
4. Breakdown of communication, even in the conditions of trust-inability to know the scope of an issue.
5. Government regulation and bureaucracy-increasing the mountains of paperwork and red tape.
6. New economic realities- forced indebtedness and the need to develop expertise in protecting one's own money.

IV. STRATEGIES TO REDUCE STRESS

Stress does not just exist in the world or happen to you. There are no anxiety attacks because anxiety does not attack. Stress is not out in the world waiting for you. It comes from the inside, from an internal thinking process. Stress does not happen to someone: Rather, the person becomes that way because of a view

of life that becomes stressful. A boss is intimidating because you choose to view him or her that way, not necessarily because of formidable traits. People and things in life are just the way they are. If you have stress in your life it is because you choose to judge people and things in a way that fills you with tension. Tension is an unnatural experience. All animals except humans avoid internal strife, except as a survival mechanism or as a warning against danger. People on the other hand, have useless anxieties subjecting their bodies to psychophysiologic disorders such as hypertension and ulcers, and ultimately shortening their lives. The person who feels an inherited tendency toward stress or is simply a tense person is likely to stay that way for the rest of his or her life. However, there are steps to be taken toward tranquility and peace of mind. If stress comes from the choice one makes, then there are specific strategies to become a more relaxed, content person and rid oneself of tension and anxiety.

These strategies are:

1. Since stress shows up in the body, you must take responsibility for removing it. Any physical activity that promotes relaxation will automatically result in less stress. You may consider doing something like yoga, meditation, or other forms of relaxing body and mind exercises.
2. When you become aware of the anxiety, practice the mental control of pushing the stress-producing thoughts aside for 60 seconds and eventually lengthen the time interval. While this may seem simplistic, it is a basis for ridding oneself of self-defeating thoughts.
3. Tame the hurry sickness in driving, shopping, eating, making love or vacationing. Postpone certain tasks in favor of some relaxation when you feel like it.
4. Avoid too many deadlines. Take your watch off for a day and enjoy the freedom from the pressure of time.
5. Quit trying to be a perfect husband or wife, employee or boss, homemaker or whatever. Since you will never be fully appreciated, you will be doing others a favor if you teach them to take care of themselves.
6. Be able to say "NO" firmly to obligations which would bring too much pressure into your life. You can relieve yourself of many unnecessary pressures by not taking on new tasks in order to please others.
7. Develop ways of changing unpleasant or unproductive personality traits. For example postponing an outburst of anger for a few minutes may allow you to eliminate one

horrible situation through this technique thus removing some stress from your life.

8. Take one hour a day just for you. Though you may feel guilty at first, tell yourself that you are worth it, as you jog, meditate or write, or do something you enjoy. Make privacy a regular part of the family environment by respecting others' privacy and having a place in your home in which you can feel alone without having to constantly feel that your space is being invaded.
9. Develop cheerfulness and humor. Smile and say hello to five strangers daily. It will lower your stress, even only to know that you've relieved another person's burden with a smile.
10. Add variety. Don't do things the same way all the time. "Step out of the box".
11. Remember that neither chemicals nor alcohol solve problems. Seek professionals who are interested in helping you reduce dependencies rather than those who encourage you to gulp tranquilizers as an antidote to stress. Keep in mind that you want to be in charge of your life rather than be numbed or comforted by drugs or drink.
12. Avoid a too sedentary lifestyle. Too much sitting and not enough activity lead to stress, overweight or depression. Foster movement by jogging, swimming or walking.
13. Decide early in the morning what undesirable chores you want to complete that day and get them out of the way as soon as possible. Once completed you will feel a sense of relief from the tension concerning what you had to do.
14. Finally, love and respect yourself at all times. Stress often results from self-rejection and can be corrected. The choice to be without tension, stress or anxiety can be made immediately now.

(This paper has been adapted from "Stress: New Ways to handle it" by Wayne Dwyer and Managing Stress by Chandra Patel).

STRESS MANAGEMENT IN AVIATION

LEARNING OBJECTIVE: Recognize the signs of stress and understand the principles of stress management.

I. INTRODUCTION

- A. Stress reduces performance and precludes safety.
- B. The combination of stress, speed, fatigue, and errors in aviation lead to accidents.

II. CHARACTERISTICS OF A HEALTHY INDIVIDUAL

Normality in mental health is not only defined as the absence of neurotic and psychotic symptoms but also as the state of "emotional maturity". Emotional maturity includes: the ability to be guided by reality, the presence of good work adjustment, the use of long-term values, the capacity to love someone else but with an enlightened self-interest, the use of adaptive defense mechanisms, and the presence of good sexual adjustment with acceptance of own gender. Emotional maturity as defined here affords the individual to have the following characteristics:

- A. **Flexibility:** Ability to adjust to inconvenient changes in schedules and plans without major emotional turmoil.
- B. **Reliability:** Ability to commit to responsibilities and be dependable.
- C. **Job Satisfaction:** Ability to be productive and enjoy the job.
- D. **Financial Solvency:** Balancing expenditure with income.
- E. **Physical Fitness:** Maintaining health, weight, and body conditioning.
- F. **Maintaining Significant Relationships:** Particularly those maintained on a long-term basis.
- G. **Social Participation:** Ability to socialize comfortably when required to do so as part of personal and professional life.
- H. **Planning:** Ability to anticipate and plan for the future, develop and achieve goals, and provide security for self and significant others.

III. DEFINITION OF STRESS & STRESS REACTIONS

- A. Stress is any change (rapid, frequent, unexpected) in the environment that forces a person to make adjustments or adaptations.
- B. Stress Reactions are, respectively, the emotional and physical wear and tear on the mind and body resulting from coping with life's problems and events.
- C. Fight or Flight are the instinctual reactions promoted by the physiological consequences of adrenaline - like rush that occurs in response to stress.
- D. *Stress is one of the necessities of life:* The more stress, the more stamina, growth, and seasoning an individual may acquire.
- E. *Stress management is a learned skill:* experience, age, psychological maturity are favorable factors.
- F. CNS changes occur as a result of long-term consequences of hyper-alertness when there is no time to get back to homeostatic baseline. These changes compromise an individual's ability to manage modern day stress.

IV. STRESS RISK FACTORS

- A. *Compulsive (Type A) Personality:* Individuals with compulsive traits are usually compelled to display the following behavior:
 - 1. Over-planning and over-extending themselves.
 - 2. Carrying out multiple thoughts and actions simultaneously.
 - 3. Micromanagement of others.
 - 4. Inability to delegate.
 - 5. Time urgency and impatience with delays.
 - 6. Continuous sense of guilt and concerns that things should not go wrong.
 - 7. Misuse of leisure time.
 - 8. Competitive drive and need to win.
 - 9. Desire for recognition and the acquisition symbols of success.
- B. *Faulty patterns of thinking:*
 - 1. Expecting to always know the right answer.
 - 2. Expecting everything to turn out for the better.
 - 3. Assessing one's happiness by the approval and love by others.

4. Discounting one's thinking vs. others' expectations.
5. Presuming that others always think the same way one does.
6. Concluding that people are selfish and uncaring.
7. Dreading the unknown.
8. Invariably allowing one's feelings to dictate one's behavior and decisions.
9. Evading the assumption of responsibilities and difficult tasks.
10. Assuming that past mistakes ruin the future or assuming that it is too late to make necessary corrections.
11. Assuming that when alone, one cannot be fulfilled or happy.

V. STRESS REACTIONS

A. *Adequate Stress Management*

1. Mental alertness, sharp perception, improved memory and recall, effective thinking, and problem solving.
2. High energy, quick responses, enthusiasm and exhilaration.
3. High motivation, self-confidence and sense of well being.
4. Flexibility, reliability, and adequate performance.
5. Regular employment, adequate income, job satisfaction, and financial stability.
6. Regular recreation, social participation, strong family ties, long-term friendships, and realistic goals in life.

B. *Inadequate Stress Management*

1. Impaired sense of one's limitations.
2. Inability to assess potentially troublesome situations.
3. Inability to get along with peers and supervisors.
4. Less stable interpersonal relationships.
5. Ineffective Leadership skills.
6. Personality Changes.
7. Excessive indulgence of alcohol, tobacco, caffeine, and drugs.
8. Financial problems.
9. Frequent changes in major career decisions.

C. Pilot Errors as a Symptom of Inadequate Stress Coping (Alkov, Gaynor, and Borowsky: *Aviation, Space and Environmental Medicine*, March 1985): Alkov et al found that the majority of aviators who had aircraft accidents felt to be due to pilot error in their study reported the following difficulties:

1. Financial problems.
2. Recent marital engagements or problems.

3. Career decision to leave aviation (possibly due to awareness of becoming a failing aviator).
4. Personality Factors: Non-introspective, lack of maturity, no sense of own limitations, and inability to assess potentially troublesome situations.

D. *Symptoms of Impaired Stress Management:*

1. Cognitive:

- a. Inattentiveness, distractibility, forgetfulness, disorientation, and confusion.
- b. Worry, dread, fears, nightmares, and pessimism.
- c. Decline in motivation and self-doubt.

2. Emotional:

- a. Irritability, agitation, and argumentativeness.
- b. Emotional lability, then panic and depression.

3. Behavioral:

- a. Decline in work performance and productivity.
- b. Withdrawal and avoidance of others.
- c. Impatience, carelessness, sarcasm, and hostility.
- d. Increased consumption of alcohol, nicotine, caffeine, and prescription tranquilizers.
- e. Aircrew who "act out" aggression by assaulting other people or inanimate objects may be prime candidates for aircraft mishaps (Alkov et al).

4. Physiological (Fight / Flight Syndrome):

- a. Muscle Tension: Cramps, headaches, backaches, tremors, foot tapping, pacing, twitching of eyelids, tightness in throat and chest, shortness of breath and fatigue.
- b. Increased Heart Rate: Palpitations, high blood pressure, stroke, heart attacks etc.
- c. Increased Breathing: Hyperventilation, changes in blood chemistry.
- d. Increased Perspiration: Loss of fluid, thirst, dehydration, etc.
- e. Disturbance in Metabolism: Liver releases more glycogen, pancreas produces more insulin initially (hypoglycemia) then unable to produce enough insulin (hyperglycemia), increased fat in the blood stream, cholesterol build-up, and hardening of the arteries.

- f. Decrease in Gastrointestinal Functions: Loss of appetite, indigestion, gastritis, ulcers, colitis, spastic colon, and diarrhea.
- g. Decrease in Saliva and Mucous: Dry mouth, poor indigestion, bad breath.
- h. Constriction of Blood Vessels: Cold hands and feet, itchy and dry skin, eczema, skin ulcers, circulation problems, and fainting.
- i. Bone Marrow Changes: Increase in red blood cells leading to increased blood clots, decline in the function of the immune system leading to increased susceptibility to diseases, or cancer.
- j. Insomnia: Changes in Circadian Rhythm leading to hormonal changes, fatigue, lack of muscle coordination, and increased startle reaction.

VI. PRIMARY PREVENTION OF STRESS CONSEQUENCES

Primary Prevention is implemented by the individuals themselves. The Flight Surgeon takes a proactive role in providing information, teaching, and participation in the Command's effort to promote stress management programs. Such programs include but are not limited to the following:

A. *Selection of Personnel:*

- 1. Select those who have demonstrated grace under pressure, capability to be team players, common sense, and good judgement.
- 2. Exclude those with unstable personalities (history of personality disorders), inadequate coping abilities or poor motivation.

B. *Training of Personnel and teaching Stress Management Programs:*

- 1. Physical Fitness
- 2. Realistic Self-Assessment: Realistic goals, priorities and effective planning.
- 3. Recreation and Relaxation.
- 4. Emphasis that well-learned skills are the least likely to break down under stress.
- 5. Complicated tasks require more mental capacity and can be vulnerable to stress.

C. *Train supervisors to observe inadequate stress coping as manifested by:*

1. Maladaptive defenses mechanisms
 2. Disciplinary problems.
 3. Recurrent interpersonal problems.
 4. Noticeable change in behavior or affect.
 5. Alcohol/substance misuse or abuse.
 6. Suicidal ideations or behavior.
- D. *Inform Chain of Command* regarding high intensity or long duration stress such as before or during deployments, gearing up for various inspections, or critical incidents.
- E. *Create an environment for Change.* Change is the most important factor that will be imperative to deal with on a daily basis. There is rapid and frequent change that is occurring in today's Navy and the Health Care Field. It has been said that we make more decisions in one month than our grandparents did in a lifetime. The only things we can control about change are our own attitudes and responses. To create a healthy environment for change the following ideas are recommended:
1. Determine the need for change and the consensus by those affected.
 2. Ensure open mindedness and open communication.
 3. Prepare for change by setting goals. Goals must be clear, understood, and meaningful. Give everyone a common goal. Re-evaluate or re-set goals as necessary.
 4. Instill confidence that change will benefit the group. Celebrate small victories along the way. Don't wait for the final results to be achieved.
 5. Obtain leader(s) support.
 6. Allow for mistakes. Turn a bad experience into a learning experience.
 7. Maintain appropriate perspective. Find the 15% where you have a positive influence and work on it. Make small increment changes as opposed to 100% change from the outset. Allow for initiatives and creativity and empower others to do what they know best.
 8. Separate who you are from what you do: Do not become your job.
 9. You must have concern for yourself in addition to concern for subordinates. Work collectively.
 10. Learn to find fun and joy in your work. Lighten up the work place through humor. Humor enhances productivity, morale, and team building.

11. Maintain balance in you life.
12. Have a hobby that is not related to your work.
13. Be persistent. Learn when to steer, when to rest, and when to go with the flow. Steer where there is a momentum for positive change. Seize the opportunity to turn adversity into a good situation.

VII. SECONDARY PREVENTION OF STRESS CONSEQUENCES

Secondary Prevention requires that the Flight Surgeon takes a more active role in steering and marketing the following measures when he/she begins to observe increasing stress reactions among members of the squadron or unit:

- A. *Actively implement Primary Prevention measures.*
- B. *Establish ongoing Stress Management Programs (refer to Appendix B):*
 1. Diet.
 2. Sleep (Crew Rest).
 3. Exercise.
 4. Relaxation (Diversion and Pleasure).
 5. Time Management/Prioritization of Tasks.
 6. Minimization of alcohol, caffeine, and elimination nicotine and drugs.
 7. Communication (teach aircrew to verbalize concerns vs. acting out).
 8. Recognition of Limitation.
 9. Encouragement of religious or personal spiritual programs (in moderation).
 10. Community Involvement.
- C. *Conflict Management and Containment:*
 1. The Flight Surgeon may be called upon as a consultant to assist in resolving a conflict between two individuals or two units.
 2. Define the problem and stick to the issue(s).
 3. Control anger which causes digression and confusion between the main issues and personal agendas.
 4. No need to prove superiority. Think of a Win/Win* strategy.
 5. Look for positive and mutual grounds that will merge everyone's interest and energy. Begin with the end in mind.*

6. Endorse a Change-First attitude. Everyone wants to change the world and no one wants to change themselves. If one individual shows willingness to change trust will begin to build up between all concerned.
 7. Observe physical signs of anger and immediately intervene and redirect.
 8. Foster trust, communication, and confidence.
 9. Provide feedback on process and outcome. Follow-up after several days or weeks to ensure that everyone is on the right track and motivated to work together.
 10. Master the art of listening. Listening is hearing, interpreting, and evaluating before responding. Monitor non-verbal behavior while listening. Maintain eye contact. Repeat what people say and ask for clarification if necessary. Try to get into the speaker's form of reference. Beware that some people are not listening while you speak... they are merely waiting their turn to speak.
 11. Seek first to understand and then to be understood.*
- D. *Develop and Role Model Your Own Stress Management Program to your patients and peers.***
- E. *Establish and Maintain Support Systems which include:***
1. Family or Significant Other involvement.
 2. Problem-Solving or Work-Counseling groups with senior members as mediators or coaches.
 3. Community involvement by active duty members.
- F. *Ally with those who provide counseling services such as chaplains, Family Services, Mental Health Department, and Financial Counselors.***

* Adapted from "The 7 Habits of Highly Effective People" by Stephen R. Covey. A Fireside Book published by Simon and Schuster, New York, 1990.

APPENDIX B

SELF-PACED AIRSICKNESS DESENSITIZATION PROGRAM (SPAD)

I. GENERAL DESCRIPTION:

Motion sickness is the "normal" reaction of travelers to a moving environment. Thus, anyone will become sick with sufficient motion and mismatched sensory stimulation. This affliction of travelers has been noted throughout history. The problems caused by motion sickness are as numerous as the implications for safety in flight. The parameters of this illness and its aviation-compatible treatment methodology have, as yet, defied the research efforts of many decades.

The Naval Aerospace and Operational Medical Institute Department of Psychiatry in conjunction with the Internal Medicine Department have been assigned the gate keeping task of evaluating and treating airsick flight personnel, based upon the presumption that the airsick patient may also have anxiety that elevates physiological motion sensitivity. Therefore, a dose of "anti-anxiety/relaxation" biofeedback assisted might help to settle the proverbial stomach. There is some truth to this assertion, though it is not nearly as simple as it might sound.

There are two basic types of airsickness patients seen-the aviation student early in flight training, and the designated aviator sent to NAMI on TAD orders by his/her command. Students are, by far, the most numerous. Depending upon the type of training (Student Naval Aviator (SNA), Naval Flight Officer (NFO), etc.), it is estimated that between 10 and 60 percent of these students develop airsickness during their first six flights. Ninety-five percent acclimate spontaneously, provided they are motivated to fly.

Airsick flight students are referred by their flight surgeon. Usually the patient has had several flights which have culminated in repeated emesis and related symptomatology such as dizziness, headaches, urinary frequency, fatigue, anticipatory anxiety, etc. Often times, there is a marked degradation in flight performance as well. Scopodex has been used for three to five flights in an attempt to desensitize by providing flight experience without airsickness. The student's motivation to continue in the flight program is also assessed by the flight surgeon prior to referral.

At NAMI, the patients undergo a psychometric evaluation with specialty consultation with the Internal Medicine Department to rule out neurologic or vestibular disorders. Furthermore, a developmental history of motion sensitivity (childhood car or

airsickness, avoidance of carnival rides, or adverse reactions to other motion environments) is collected by questionnaire and intake by the biofeedback therapist. Motivation is assessed and a very strong, healthy motivation for an aviation career is a necessity for a good prognosis.

As part of the evaluation process the internal medicine department conducts a vestibular examination to determine if the motion sickness susceptibility is low, moderate, or high. If no physical or psychological problems are noted the patient is then provided 10 sessions of biofeedback in the psychiatry department before being transferred to the Spinning chair where he/she undergoes a desensitization program of 4-6 weeks.

II. BIOFEEDBACK

Biofeedback is the use of instrumentation to mirror psychophysiological processes of which the individual is not normally aware and which may be brought under voluntary control. This means giving a person immediate information about their own biological conditions, such as : muscle tension, skin surface temperature, brain wave activity, galvanic skin response, blood rate and heart rate. This feedback enables the individual to become an active participant in the process of health maintenance.

Biofeedback involves the use of very specialized instrumentation. This instrumentation may be as simple as a hospital thermometer or as sophisticated as an electroencephalogram, an electronic device that measures the brain wave patterns. The most important feature about the instrumentation, no matter how simple or complex, is that it tells the individual about the measurement which it just made. It is this important feature of measurement and immediate feedback which distinguishes biofeedback from other techniques which teach "relaxation" or "alpha control," but which do not involve feedback of actual physiological changes.

Biofeedback instrumentation gives some information about the body. There are many ways to "mirror" this information so the individual understands what changes occurred or what condition exists. The information may be conveyed by the use of a meter or light which the person watches or by a sound which is heard, or even by the movements of a toy train! Whatever means are used, the critical point is that the person gets immediate information about his or her own body. With appropriate instrumentation anything that is measured can also be fed back to the individual in some way.

Muscle tension and relaxation can be measured and fed back by the electromyograph. Sensors placed on the skin over a muscle will detect electrical activity of the muscle. More electrical firings indicate greater muscle tension. People are not aware of areas which are tense until it becomes painful.

Arousal changes, due primarily to sympathetic nervous system changes, are measured by the Galvanic skin response. It measures changes in sweat response on the surface of the skin, usually the hand. As it is used in biofeedback, the individual can get the feedback on their own arousal system.

Peripheral blood flow can be measured by measuring the temperature of the surface of the skin by the use of temperature biofeedback. Changes in the dilation or constriction of the peripheral vessels lead to changes in blood flow. For example in a constant environment, skin surface temperature of the hands can fluctuate between 60-95 degrees. Minute changes in the skin temperature are measured by a thermistor placed on the surface of the skin and fed back to the individual.

The two steps in the biofeedback learning process are awareness of body states and voluntary control over these states. A third step involves using these new skills in everyday life. The use of biofeedback instrumentation is merely a means to an end. It is very useful learning technique whereby the individual can learn to control certain physiological processes. The "end" is that the person can exercise this voluntary control without the use of instruments. Therefore, the goal is to learn to lower muscle tension, or blood pressure, or increase hand temperature, etc. whenever necessary (in the aircraft). The biofeedback therapist helps the patient to integrate the biofeedback training to his or her daily living with various techniques including home practice exercises. The patient and therapist also discuss situations which are stressful and anxiety-producing so that patient has a more complete understanding of the psychological and physiological interactions. Biofeedback allows self-control through increased awareness of stress responses and the ability to voluntarily control these responses.

Patients in the program are received from world wide Flight Surgeons referrals. Saudi Arabia, Italian and Kuwait pilots have been treated in the program. Nevertheless, our referrals come from the entire aviation community with the bulk of the referrals being from the local area. All patients undergo a course of muscle relaxation and cognitive rehearsal therapy. Ten sessions over a five day period are completed in the psychiatry department before the patient is referred to the SPAD chair for desensitization and during this 4-6 week period the patient undergoes biofeedback training and heart monitoring twice daily. Patients carry out home assignments and are encouraged to exercise and get involved in activities designed to help them relax and acclimatize to vestibular stimulation without motion sickness.

Upon completion of both treatment regimens, the patient is returned to his/her command for two ungraded trial flights. Based on in-flight performance, a decision is made by the flight surgeon whether or not to recommend retention in the flight program.

Perhaps this sounds simple, but it isn't. Treatment effectiveness, patient adaptation, placebo effects, etc., may be quickly evaluated in the aviator. However, this is more difficult with SNFO's and other air crew because they often return to flights with low motion stimulation and do not experience much provocation until they get their operational assignments. Then they "wash out"!

The evaluation and treatment of designated aviators is more difficult. More experienced and, theoretically, having undergone long hours of motion adaptation, it is more difficult to design a desensitization program for them. These patients may begin to experience their airsickness at periods of critical change in their aviation career; for example, motion sensitivity may develop during transition to a different aircraft or mission. Again, applying the analogy of stress-overload-induced airsickness symptoms the flight surgeon may be well advised to carefully evaluate these aviators. An adequate trial of six more flights in the new assignment is in order. Patients who remain symptomatic but who demonstrate high motivation for unconditional flight assignments are good candidates for SPAD. According to Captain Roger Reinhardt, MC, USN, Ret., these aviators should have strong family and command endorsements to return to their assignment following evaluation and treatment.

III. SPAD PROGRAM CURRICULUM

The Self Paced Airsickness Desensitization Program embodies Autogenic Training, Temperature Training and Jacobsens Relaxation Training. The program is divided into ten one hour sessions. During this time the patient is introduced to biofeedback, foods to avoid and a vigorous exercise program. Autogenic Training is "a psychophysiologic Self-control therapy" and "a psychophysiological form of psychotherapy which the patient carries out himself by using passive concentration upon certain combinations of psychophysiological adapted stimuli" (Luthe, 1963). Above all the emphasis is on self-control and patient administered.

Autogenic therapy is considered self-hypnotic. The role of the therapist is to instruct and guide while encouraging self control. The vehicle is of organ specific changes. The patient is taught individually in a quiet atmosphere with the minimal of noise and interruption. The room temperature is kept at 68-72 degrees with the patient in a recliner. The room is slightly darkened and comfortable. The chair is not reclined, the elbows are kept at nearly a right angle because in this position the stretch and bend muscles in the arm are at a balanced state. The training begins with one arm—a right handed person with the right arm and a left-handed person with the left arm. If one arm has been trained properly the relaxation and heaviness will generalize to other body systems since all extremities and organs are accessed by the same nervous system.

Autogenic training has been found effective in the treatment of various disorders of the respiratory tract such as hyperventilation and bronchial asthma. Disorders of the gastrointestinal tract (constipation, diarrhea, gastritis, ulcers and spasms), the circulatory system (racing heart, irregular heartbeat, high blood pressure, cold extremities and headaches. It is also helpful in reducing general anxiety, irritability and fatigue. It is also helpful in reducing general anxiety, irritability and fatigue and increase your resistance to stress.

Each patient is introduced to a variety of relaxation techniques while undergoing the first week of training. First is the ability to express any anxiety, misgivings, or ambivalence felt toward flying. How anxiety about becoming airsick contributes to actual motion sickness was explained and compared to the familiar visceral effects of stage fright or pre-athletic contest anxiety. The importance of the patients full cooperation and active participation in forming a treatment partnership is emphasized.

The patients are taught the rudiments of deep muscle relaxation using an abbreviated form of Jacobsonian contraction and slow relaxation techniques, as well as diaphragmatic breathing and mental imagery. The role of relaxation in aborting motion sickness is explained and reinforced during subsequent sessions and later in the rotating chair. Simply stated, the patients are told that the cold, clammy feeling that accompanies the onset of airsickness will not progress in people who know how to keep themselves warm and dry, and they will learn this skill by using biofeedback instruments to measure their skill in warming their hands and lowering their skin conductance response.

"This paper is adapted from the works of Captain Roger Reinhardt, MC, USN (Retired)."

IV. BIOFEEDBACK INSTRUMENTATION INCLUDES

- A. The skin surface temperature: This temperature is processed by the feedback instrumentation (J & J I-330), taken by a thermistor taped to the distal fleshy aspect of the middle finger of the patient's left hand. Small changes in temperature are fed back in the form of an analog digital readout of the absolute skin temperature.
- B. The electrodermal response: The electrodermal response reflects the tonic level of perspiration-mediated electrodermal activity. This reflects autonomically modulated phasic changes in electrodermal activity. This response is measured by electrodes strapped to the distal fleshy aspect of the second and fourth fingers of the left hand which is connected to the feedback instrumentation (J&J I-330), taken by two velcro attached instruments to the first and third finger of the left hand. Any changes are fed back in the form of an analog signal.

C. Session 1 - 10

1. A psychophysiological profile is done before the first session of biofeedback. Three modalities, (1) Electromyography (EMG), (2) Temperature (Temp), and (3) Electrodermal Skin Response (EDR) are attached to the patient's body. This session is structured as follows:
 - a. Five minutes of relaxation with eyes open or closed
 - b. Five minutes of serial 7's
 - c. Three minutes of relaxation
 - d. Four minutes of various sounds with eyes closed
 - e. Three minutes of relaxation with eyes closed. No feedback is offered during this session.
2. The patient is informed of the basic rationale for biofeedback. In other words, they are told that it is a way to learn to control bodily responses, that one does not normally consciously control, that the equipment will provide information about changes in their bodily state, and that their goal is to develop an awareness of their bodily sensations associated with relaxation.
3. Each session consists of a 10-minute acclimatization interval followed by 25 minutes of multimodal (TEMP and EDR) biofeedback training. Immediate auditory analog feedback occurs during temperature training and visual feedback accompanies EDR changes. Additional feedback in the form of verbal reinforcement is provided periodically by the therapist who is present throughout all sessions. Whenever the patient exhibits an unusually large magnitude response the therapist says "Good!".
4. The procedure during sessions 2-10 is identical to that of session 1 except that the initial acclimatization interval is 5 rather than 10 minutes.

PSYCHOTHERAPIES

I. DEFINITION

Psychotherapy is any treatment designed to produce a response by mental rather than by physical effects, including the use of suggestion, persuasion, re-education, reassurance, and support, as well as the techniques of hypnosis, abreaction, and psychoanalysis.

II. TYPES OF PSYCHOTHERAPY

The types of Psychotherapy discussed in this chapter are those used in military psychiatry. The frequency of their use depends on the military treatment facility and the clinician. These include: Supportive Psychotherapy, Behavior Therapy, Biofeedback, Cognitive / Rational-Emotive Therapy, Self-Help groups, Marital-Family Therapy, Group Therapy, Hypnotherapy, Bibliotherapy, Psychodynamic Psychotherapy, and Crisis Intervention.

III. SUPPORTIVE PSYCHOTHERAPY

Supportive Psychotherapy is probably the commonest form of therapy that is provided during most clinical encounters (psychiatric and non-psychiatric) between a health care provider and a patient. Often, the Flight Surgeon is the only Medical Officer with the most psychiatric expertise such as on Aircraft Carriers or remote Air Stations. With a few exceptions such as severe depression or psychosis, supportive psychotherapy is used when symptoms are insufficient to warrant intensive psychodynamic psychotherapy. It reinforces the patient's defenses and helps him/her suppress disturbing psychological material, while avoiding the vulnerability of emotional conflicts. Supportive psychotherapy focuses on the here and now, assists the patient in forming a realistic perspective of his/her predicament, provides him/her with some suggestions, and encourage him/her to develop a problem solving plan that will be effective and appropriate. The role of the physician is more or less that of a coach who provides objective feedback, options, and prognostic estimates based on scientific, academic, and clinical data and professional experience.

IV. BEHAVIOR THERAPY

Behavior Therapy is a therapeutic approach in which the focus is on the patient's observable behavior, rather than on conflicts and unconscious processes presumed to underlie his/her

maladaptive behavior. This is accomplished through systematic manipulation of the environmental and behavioral variables related to the specific behavior to be modified. Operant conditioning, systematic desensitization, token economy, aversive control, flooding, and implosion are but a few examples of techniques that may be used in behavior therapy.

V. BIOFEEDBACK

- A. Biofeedback is the use of instrumentation to mirror psychophysiological processes of which the individual is not normally aware and which may be brought under voluntary control. This means giving a person immediate information about his/her own biological conditions, such as muscle tension, skin surface temperature, brain wave activity, galvanic skin response, blood pressure, and heart rate. The feedback enables the individual to become an active participant in the process of health maintenance.
- B. To be clinically effective, the biological process must be:
 - 1. Physiologically relevant, and
 - 2. Psychologically meaningful to the patient.
- C. The patient must be able to cognitively relate to the feedback and to changes in the biological process.
- D. Secondary learning will take place in which the patient learns to monitor his/her general body state (how it feels), thus becomes able to judge and appropriately alter physiological arousal without the use of instrumentation.
- E. Clinical applications include the treatment of headache, hypertension, Raynaud's Syndrome, irritable bowel, ulcer, motion sickness, etc.

VI. RATIONAL - EMOTIVE THERAPY

- A. The purpose of Rational Emotive Therapy (RET) is to combat distorted thinking. Its theory assumes that painful emotions are unnecessary, self-induced, and come from distorted perceptions, distorted thinking, and faulty conclusions made about the world. This eventually leads to ongoing interpersonal conflicts. This is also considered a form of cognitive therapy by some authors in stressing that changes (reduction of symptoms) will occur and be longlasting if the patient modifies his/her belief system and ways of conceptualizing about self and others, and if he/she makes rational decisions to alter the course of his/her life.
- B. The goal of RET is to help the patient differentiate between facts, self-talk, and emotions.

C. *Types of Distorted Thinking:*

1. Filtering: Filtering out positive aspects of the situation.
2. Polarized Thinking: Black or white, no middle ground.
3. Over-Generalization: Based on single piece of evidence, the same thing is expected to happen over and over again (also called global labeling).
4. Mind Reading: Assuming that one is always able to predict what people feel (projection).
5. Catastrophization: What if..? etc.
6. Personalization - Patient thinks that everything people say or do is in reaction to him/her. Another form is when the patient always compares himself/herself to others.
7. Control Fallacies: Feeling victimized and controlled by others (or vice versa).
8. Fallacy of Fairness: Resentment due to thinking that others do not agree with what the patient thinks is fair.
9. Blaming: Holding others responsible for one's pain.
10. Shoulds: Having a list of ironclad rules about how one (or others) should act.
11. Emotional Reasoning: Assuming that others always feel the same about similar situations.
12. Fallacy of Changing Others: The patient's need to change others due to the fallacy that their standards of happiness are the same as his/hers.
13. Being Right: The patient continually needs to prove that his/her opinions and actions are correct. Being wrong is unthinkable and intolerable.
14. Heaven's Reward: The patient expects his/her sacrifice and self-denial will pay off. Feels bitter when the reward does not come.

D. *Intervention by the Rational Emotive Therapist:*

1. Identify the painful emotions.
2. Describe the associated event/situation.
3. Recognize indicator(s) of the maladaptive cycle.
4. Prevent automatic (distorted) thinking or self-talk by providing rational explanation of the situation, facts, and consequences or outcomes.

VII. SELF-HELP GROUPS

- A. Self-Help groups usually follow the prototype of Alcoholics Anonymous.
- B. They are commonly "Twelve-Step recovery programs".
- C. They can be located through the yellow pages, local paper, or Navy Family Service Centers.
- D. They are very helpful but patients need to shop around for groups that are suitable to their specific needs.

VIII. MARITAL / FAMILY THERAPY

- A. Marital or Family Therapy is focused on dysfunctional relationships between the individuals in the marriage or the family. The focus is on the communication, expectations, and role assignments each member has. Improvement is seen when each person in the relationship learns about him/herself, about the other person, and the most effective way to communicate with one another.
- B. This type of therapy is provided at the Navy Family Services Centers and is also covered by CHAMPUS for the benefit of the CHAMPUS eligible family member(s) in the relationship.

IX. GROUP THERAPY

- A. The group process is a forum for the recapitulation of the patient's primary family. Social interactions and skills are identified and discussed among the members of the group.
- B. Group Therapy benefits patients through experiencing and observing others in a medium where there is universality of conflicts, imitative behavior, learning from others' positive and negative experiences, group cohesiveness, altruism, and CATHARSIS which is the expression and discharge of repressed emotions and ideas.
- C. The group therapist must be skilled in coordinating the group process, focuses on the "Here and Now", and restore hope through the interactions among the group members. Some groups may adopt an intense psychodynamic approach and delve into past experiences beyond the here and now.

X. HYPNOTHERAPY

- A. The use of hypnosis in the evaluation and treatment of certain psychiatric disorders.
- B. Hypnosis is an artificially-induced passive state in which there is increased amenability and responsiveness to suggestions and commands, provided that these do not conflict seriously with the subject's own conscious and unconscious wishes.

XI. BIBLIOTHERAPY

- A. Bibliotherapy is the process of recommending suitable reading material for the patient's education and self-improvement in regards to a subject relevant to his/her problem.
- B. It is helpful in many cases particularly when the patient is insightful, educated, self-monitoring, and motivated.

XII. PSYCHODYNAMIC PSYCHOTHERAPY

- A. **Definition:** It is a change brought about through intra-personal and interpersonal action.
- B. It is either used singularly or integrated with other modalities such as pharmacotherapy, behavior, cognitive or rational-emotive therapy.
- C. **The genesis of psychodynamic psychotherapy** is the psychoanalytic theory of Sigmund Freud.
- D. **Brief psychotherapy and crisis intervention** are modified psychodynamic therapeutic modalities which derive formulation or understanding of the patient's behavior from the psychoanalytic theory in order to resolve or assist the patient in coping with intrapsychic or interpersonal conflicts.
- E. Psychodynamic psychotherapy is administered as one-to-one modality or within the context of group therapy.
- F. **What is PSYCHOANALYSIS ?**
 - 1. Psychoanalysis is a research technique created by Freud to explore the furthest corners of the unconscious which was eventually found to have therapeutic value.
 - 2. It applies a closed-system model of therapy. This model assumes that all unconscious conflicts and libidinal fixations need to be worked-through to resolve the patient's symptoms.
 - 3. It is also viewed as a reconstructive therapy requiring the patient to regress and develop transference neurosis toward the analyst through the use of free association.
 - 4. It is very intensive, long-term, and usually requires the patient not to have eye or face-to-face contact with the analyst in order to enhance the free association process.
- G. **What is PSYCHODYNAMIC PSYCHOTHERAPY ?**
 - 1. Psychodynamic psychotherapy can be long-term or brief. The long term is occasionally called psychoanalytically-oriented psychotherapy.
 - 2. It applies an open-system model of therapy. This model enables a patient to function more effectively in a particular area leading to improvement of self-esteem, positive feedback from the environment, and resolution of the relevant intrapsychic conflicts. These outcomes reinstate the psychodynamic homeostasis without having to work-through all unconscious conflicts as in the closed-system model.
- H. **Indications of Psychodynamic Psychotherapy:**
 - 1. Psychodynamic Psychotherapy in general is useful when the

patient is in a state of conflict but not necessarily in crisis (see crisis intervention).

2. Existence of a focal conflict: Oedipal, aggressive, dependence/independence, sibling rivalry, difficulty in coping with object loss.

3. Long-term psychotherapy is useful with patients who have seriously impaired ego integrative capacities particularly with severe personality and borderline disorders.

4. Short-term (brief) psychotherapy, which is commonly used in the military, is indicated for Adjustment Disorders and/or mild forms of depression and anxiety. Generally speaking, it is useful when there is absence of characterological problems and when there is a strong motivation to improve the adaptational pattern of personality traits and defense mechanisms which led to behavioral disturbances or subjective distress.

I. How does Psychodynamic Psychotherapy work ?

1. Psychodynamic formulation must be initially performed to assess the inner and outer forces that contribute to the patient's psychopathology.

2. The primary goal of psychotherapy is to modify adaptive and coping skills which ultimately lead to reduction and relief of stress.

3. For a successful psychotherapy to occur, the patient must have the capacity to effectively work-through relevant unconscious intrapsychic factors. This capacity can be ascertained through the presence of:

- a. Ego strength, intelligence, educational and occupational achievements, sexual adjustment, and ability to assume responsibility and autonomy.
- b. Basic trust as evidenced by at least one meaningful interpersonal relationship in the past.
- c. Transference (not transference neurosis) as evidenced by the ability to benefit from the interaction with the therapist regardless of whether there are pleasant or unpleasant feelings imported from past relationships.
- d. Insight as evidenced by the ability to experience and describe feelings and conflicts, and accept interpretation.

4. During psychotherapy the following elements must occur:

- a. Catharsis: Release of tension in a setting of hope

and expectation of help. The patient releases tension by verbalizing the perceived difficulty while therapist expresses empathy.

- b. Setting a Time Limit: This places a central emphasis from the beginning on the issues of separation and individuation, encourages the patient to maintain autonomy, reduces the patient's impulse to feel helpless, inadequate, and in need of dependent support. In brief psychotherapy anywhere from 6 to 30 sessions can be agreed upon depending on the therapist's clinical judgement. Follow-up visits after three to six months from completing psychotherapy can also be discussed at the initial phase of therapy.
- c. The patient must be sitting-up and facing the therapist. This allows for a more interactive process.
- d. Suggestions and Persuasion may be initially or temporarily effective through the expert authority of the physician, but occasionally lead to non-lasting quick cures. It must be followed by insight, clarification, interpretation, and corrective emotional experience.
- e. The patient must perceive that therapist has regard and concern for him/her. The activity of the therapist reflects interest in and concern for the patient's welfare and avoids the traditional "abstinence" stance of psychoanalysis. By adhering to the central focus of therapy and the patient's core conflict and actively disallowing defensive digressions the therapist maintains a high level of therapeutic tension. This is considered an "anxiety-provoking" technique recommended in some literature to compel the patient to attain the desired changes quickly.
- f. Therapeutic Alliance between patient and therapist is the most important factor in making change. The patient's response to clarifications, interpretations, and even confrontations is favorable when the therapeutic alliance is strong. The risk of suicidal behavior is substantially alleviated in the presence of a therapeutic alliance.
- g. Identification with the Therapist occurs when the patient unconsciously models after the therapist incorporating some of the latter's value systems and/or behavioral patterns. This usually occurs with or without the therapist's awareness. Recent

literature emphasized the necessity of recognizing the differences (as well as similarities) between the patient's "world view" and that of the therapist's in order to enhance the therapeutic outcome.

- h. Countertransference - the unconscious feelings and reactions reflected onto the patient by the therapist - must be recognized and discussed with a (trusted) colleague or mentor since it usually interferes with the therapist's effectiveness and may lead to stalemate or harm to the patient.
- i. Clarification: The therapist may echo to the patient his/her affect-laden words in an effort to facilitate the identification of the core conflicts that need to be resolved.
- j. Interpretation: This is not made until sufficient understanding of patient's psychodynamics has been achieved. Therapeutic alliance must be established prior to offering any interpretation which is effective if given at a level the patient can understand and integrate. An interpretation describes present circumstances and past experiences and how they are correlated. Interpretations lead to insight which, in turn, leads to change in attitude, working through, and finally sustained symptomatic improvement. This process is considered a form of cognitive learning.
- k. Triangle of Insight: consists of correlating between current symptomatology (or behavior), past interpersonal relationships, and the transference relationship.
- l. Corrective Emotional Experience: Ironically, this is a form of operant conditioning in which the therapist instills hope and restores self-esteem by reacting positively and more constructively to the patient than did significant authority figures in the patient's past. Based on the therapist's overt or covert indications of approval, the patient may move in the direction of "mental health".
- m. Working-Through: A practice or rehearsal of new adaptive techniques and their use in other settings. Also considered an element of reality testing, it is usually provided in a setting of consistent emotional support from the empathic therapist.
- n. Termination: This is a phase that is important to prepare and execute properly. It occurs when the

patient has shown significant improvement in interpersonal relationships, job performance, and clinical symptoms. Beware of resistance to terminate on the part of the patient and sometimes the therapist's as well. Anticipate it and deal with it from the beginning.

- J. Combination with Pharmacotherapy:** Psychotropic Medications can be used concomitantly with Psychotherapy. Some literature advocate that psychotropic medications should not completely eliminate the patient's symptoms. Instead, they need to be titrated just enough to provide some symptom relief to allow the patient to work with the therapist but also continue to experience just enough symptoms to recognize their occurrence and their relief in relation to the psychodynamic psychotherapy.

XIII. CRISIS INTERVENTION

- A.** Crisis Intervention provides immediate relief and assistance to a person who has decompensated or in danger of decompensating in the face of internal or external stressors and has become unable to cope with the situation. This may involve Pharmacotherapy, environmental manipulation, and/or containment in a supportive inpatient psychiatric unit.
- B.** The goal of Crisis Intervention is to remove (or mitigate) the stressful situation and help the patient deal with it more effectively. This may require that the therapist formulate the psychodynamics of the patient's conflicts in order to provide or recommend a suitable disposition or change in the environment for the welfare of the patient. Nevertheless, this is not the right time to give the patient any psychodynamic interpretation or confrontation.
- C.** The technique of Crisis Intervention involves an approach that is supportive, directive, deals with here and now, and engages family members, significant others, and other support systems within the organization or the community.

XIV. CHARACTERISTICS OF THE THERAPIST

The characteristics and personality traits of any therapist are applicable to all health care providers. These include:

- A.** Positive regard for people and the ability to accept individuals as unique persons with faults and virtues.
- B. Ability to deal with resistance.** Therapists must accept the fact that the patient will resist the painful experience of examining his/her life and make the necessary changes in adaptation skills.

- C. **Ability to listen.** If the therapist does not give the patient a full opportunity to articulate concerns and conflicts, the psychodynamic formulation may not be fully understood.
- D. **Ability to tolerate witnessing painful affects.** Patients will invariably display sadness, anger, hostility, grief, hopelessness, worthlessness, helplessness, and dependency. However, the therapist must be able to maintain an objective stance without compromising empathy.
- E. **Ability to adopt a reflective attitude.** Through pertinent history gathering, the therapist may be able to experience valuable empathic understanding of how the patient interacts with his/her environment. The therapist must be able to echo his/her insight to the patient in order to make progress.
- F. Patience and willingness to wait for the patient to make changes.
- G. Capacity for introspection to detect countertransference issues.
- H. Capability to be a role model.

LEADERSHIP AND THE FLIGHT SURGEON

CAPT N. K. TAKLA

I. CRITICAL AREAS THAT FACE THE FLIGHT SURGEON

- A. **CRITICAL CASES:** these include VIP patients such as COs, XO's, Admirals or difficult patients who are difficult to diagnose, or difficult to deal with due to litigiousness or malingering. The best approach is to ensure courteous, professional, efficient, and a thorough work-up. Do not cut corners or compromise the quality of the evaluation, document thoroughly, consult with other clinicians if in doubt.
- B. **MULTIPLE RESPONSIBILITIES:** to the squadron, the hospital, the branch clinic, sister squadrons during deployment, task forces, or carrier group, etc. Correlate the mission, vision, and guiding principles of each of these organizations.
- C. **MULTIPLE LOYALTIES:** to patients, the squadron, the Navy, the Medical Corps, etc. Follow the same approach as with B.
- D. **FAMILY MEMBERS** (formerly called dependents), VIP family members, squadron family members, seductive family members, attractive family members, undue familiarity, fraternization, adultery, and UCMJ violations are areas that can become professional and personal nightmares if not treated with utmost maturity and professionalism.
- E. **The CAREER OF THE FLIGHT SURGEON** is an extremely important area that deserves attention and often represents a critical factor in his/her professional and personal demeanor. A Squadron Flight Surgeon may elect to move on to a Wing Flight Surgeon position after the first tour. This may also evolve to become a Senior Medical Officer of a Branch Clinic. Continued operational assignment may lead to higher responsibilities at a Fleet or Marine Corps Group or Air Wing. At this point the Flight Surgeon may elect (as early as after the first tour) to transition to a Residency Training in a specialty other than Aviation Medicine. Alternatively, the Flight Surgeon may wish to further his/her career in Aviation Medicine by applying for a residency in Aerospace Medicine. This will lead to a tour as a Senior Medical Officer of a carrier or a USMC division. A tour in BUMED or as NAMI staff (department head or director) may also be an option. To become NAMI CO an individual must be an Aerospace Medicine Specialist. The critical factors that

enhance climbing the ladder of success in Navy Medicine are not only the possession of clinical and academic skills, diplomas, board certification, and research achievements but also the ability to understand and apply leadership as it is adopted by Navy Medicine.

F. FITNESS REPORTS:

1. FITREPS document performance and potential as well as provide feedback to the officer. Types of feedback are not positive and negative as many people think. Feedback should be constructive and corrective respectively.
2. FITREPS must reflect in the narrative the value or impact of the officer's work and achievements on the Command and the Navy. You do not want the FITREP to read like a job description. Commanding Officers are expected to reflect the leadership contributions and potentials of the officer in regards to his/her primary and collateral duties, more so than the importance of the title or position of the officer. Areas such as concern for subordinates, resource management, support for Navy programs such as Equal Opportunity, team building skills, etc. are necessary to document in a FITREP.
3. Keep a FITREP "brag" file for yourself and your subordinates. Every time something happens and an initiative is taken, make a copy for the file.
4. Note that officers are not promoted on the basis of past contributions or service rendered, they are promoted for potential to perform in the next grade. Therefore, a FITREP is a tool to summarize individual traits and potential for the next higher rank. A consistent growth pattern on serial FITREPS of an officer is favorable. You do not want to see a decline on fitness reports. The only exceptions are when an officer is in a new job, has a new boss, or is in a new command.
5. Special Navy Career Development Courses and Training are necessary to be listed in the narrative section. Examples are Department Head School, C-4, SMRCC, NAVLEAD, subspecialty development training, etc.

G. DIVERSITY AND EQUAL OPPORTUNITY:

1. The biggest problem with diversity is when people equate differences with deficiencies thereby generating bias, prejudice, favoritism, unequal opportunity, or discrimination. Most of us make decisions on preconceived notions. We attempt to make people see things the way we see them. The ongoing changes in the Navy create diversity and therefore equal opportunity must be enforced.

2. There are three types of diversity:
 - a. Fixed: Age, gender, culture, ethnicity, religion, physical characteristics, and health.
 - b. Acquired: Values, ethics, specialty, marital status, financial status, education, political beliefs, personal and behavioral characteristics, hobbies, and interests.
 - c. Military-related: Corps, rank, position, duty station, active duty, reserves, civilian, east coast, west coast, enlisted, officer, army, air force, navy, coast guard, line, staff, career oriented, administrative, clinical, doctor, nurse, dentist, MD, DO, operational, and hospital based.
3. Diversity can generate miscommunication and misunderstanding. Look for an objective person who would validate or substantiate how you feel if you get in the middle of an adversarial diversity.
4. Ways to deal with diversity:
 - a. The old way: Ignore it, get rid of it, modify the selection criteria to exclude those who are different, make it uncomfortable for those who are different so that they leave on their own, try to mold them into the majority's way of thinking (BLM = Be Like Me), segregate them, suppress them, or fire them. Obviously, this is no longer the way to deal with diversity.
 - b. The present and the future management of diversity: Involve the diverse group in the organization, learn about your attitudes and values, generate awareness about diversity, learn about the values of each group, share yours, look for common grounds, keep from equating differences with deficiencies, and follow the "platinum rule": Be sensitive to the way others wish to be treated (supposedly, the golden rule is: treat everyone how you want to be treated).

II. DESIRABLE INDIVIDUAL QUALITIES OF THE FLIGHT SURGEON

(Adapted from "The Leader in You" by Dale Carnegie and Associates, Inc; Stuart R. Levine, CEO and Michael A. Crom, VP. Published by Simon and Schuster, NY and London; 1993)

- A. Be comfortable with solo work and capable of making unbiased and independent decisions. Leadership is founded on integrity and credibility.

- B. Avoid rigidity and complacency. Keep your mind open to change all the time, welcome it, court it, it is only by examining and re-examining your opinions and ideas that you can progress. Look at things from the other person's perspective.
- C. Stay within the boundaries of your authority and expertise. No one can possibly know everything: listening is the best way to learn. No body is more persuasive than a good listener. Take every opportunity to build confidence of the group as it pertains to your area of expertise.
- D. Be comfortable with your own identity as a physician who is working in the aviators' world. Create a shared sense of purpose. Make the group goals your goals. Be involved, stay involved.
- E. Adapt gracefully to ridicule, criticism, and avoidance by others. Many aviators avoid the Flight Surgeon for no logical reasons. Do not use your (medical) authority to react to unfavorable treatment by others. Respect the dignity of your patients. Maintain a sense of humility.
- F. Build and maintain alliances, rapport, confidence, credibility, and consistency in your daily interactions with others. Make communication a top priority. Be open to other people. Create a receptive environment for communication. You absolutely must make time to communicate. Be open to other people - above, below, and beside. Communication is to build trusting relationships. There is nothing more effective and rewarding than showing a genuine interest in other people. Look at things from the other's point of view. See outside yourself to discover what's important to someone else.
- G. Beware of the many hats you are wearing and how they overlap. Focus your attention on quality and keep it there. Productivity will follow. The ability to admit mistakes encourages creativity and taking risks.
- H. Express discomfort when there are conflicts of interest. Be slow to criticize, be constructive and corrective in giving feedback.
- I. Define priorities, affiliations, and identify loyalties. Set goals that are clear, challenging, and obtainable. Keep your eye on the big picture.
- J. Balance work and leisure. Gain strength from the positive and don't be sapped by the negative. Learn not to worry, keep things in perspective, take comfort from the law of averages, cooperate with the inevitable, and work methodically to improve upon the worst. Enthusiasm is a

feeling that has to come from inside and is made of eagerness and confidence.

III. NAVY LEADERSHIP AND SUCCESS FACTORS

The Navy Medical Department has developed 16 Success Factors which are grouped in 5 interconnected areas of leadership. These factors are the product of a study that identified the differences between outstanding and average performers in the Navy Medical Department.

QUALITY OF CARE

1. Concern for Quality:
 - a. Holds subordinates accountable for performance.
 - b. Identifies and communicates problems in patient care.
 - c. Considers patient care in making decisions.

RESOURCE MANAGEMENT

2. Planning and Goal Setting:
 - a. Sets goals, objectives, or priorities for self and/or unit.
 - b. Develops a step-by-step plan to accomplish a goal.
 - c. Anticipates obstacles and makes plans to overcome them.
3. Initiative:
 - a. Creates or improves programs, procedures, or systems.
 - b. Ensures or expedites implementation of a plan.
 - c. Assumes additional responsibility with enthusiasm.
 - d. Independently takes action to solve a problem.
4. Persistence:
 - a. Employs an alternative strategy when one's first approach is unsuccessful.
 - b. Takes repeated actions to overcome an obstacle or solve a problem.
 - c. Works over an extended period of time to solve a problem.
5. Concern for Efficiency:
 - a. Monitors use of resources.
 - b. Delegates tasks to the best-qualified person.
 - c. Evaluates cost-benefit of programs and systems.
 - d. Ensures efficient use of people, time, and resources.

LEADERSHIP AND MANAGEMENT

6. Concern for Subordinates:
 - a. Shows concern for the equitable treatment of subordinates.
 - b. Demonstrates concern for the health and well-being of subordinates.
 - c. Acts to obtain rewards, resources, or privileges for subordinates.

7. Developing others:
 - a. Ensures that subordinates have professional training opportunities.
 - b. Personally provides information, suggestions, or on-the-job training to subordinates.
 - c. Gives task-related constructive or corrective feedback to subordinates.
 - d. Expresses confidence in subordinates' ability to do the job.
 - e. Encourages subordinates to act on their own (empowerment).

8. Team Building:
 - a. Develops unit identity, group cohesiveness, or team spirit.
 - b. Asks for input from the work group.
 - c. Gets work unit together to discuss issues.

9. Conflict Resolution:
 - a. Takes action to prevent conflict from developing or escalating.
 - b. Confronts problems directly and reaches decisions.
 - c. Exercises self-control in conflict situations.

10. Clear Communication:
 - a. Ensures the clarity of instructions.
 - b. Explains reasons for decisions to ensure understanding.
 - c. Informs own staff about work issues.
 - d. Maintains channels of communication with other departments or units.

DIAGNOSTIC CAPABILITIES

11. Information Gathering:
 - a. Informally gathers information about the work unit.
 - b. Seeks information from multiple sources to deal with a specific situation.

- c. Seeks information directly from a key person or source.
- d. Uses an explicit inquiry strategy to diagnose a situation.

12. Interpersonal Assessment:

- a. Understands the needs, interests, and agenda of an individual.
- b. Is sensitive to nonverbal behavior.
- c. Identifies factors that contribute to a person's behavior.
- d. Interprets the unspoken meaning in a situation.
- e. Acknowledges own strengths or weaknesses.
- f. Learns from past experiences.

13. Analytical and Conceptual Thinking:

- a. Identifies key issues in a problem.
- b. Compares an actual situation with what should ideally happen.
- c. Sees the similarity of a problem to situations previously encountered.
- d. Sees parallels between apparently unrelated situations.
- e. Systematically considers the advantages and disadvantages of possible actions.
- f. Identifies the implications of a particular problem or situation for other departments or for the larger system.

INFLUENCE

14. Use of Influence Strategies:

- a. Attempts to persuade others by pointing out positive or negative consequences.
- b. Uses data to influence.
- c. Develops situations to influence others.
- d. Markets an idea or proposal by talking to others.
- e. Writes for impact.
- f. Influences through others.

15. Political Sensitivity:

- a. Demonstrates awareness of the agenda of a group.
- b. Keeps superiors informed, especially on sensitive issues.
- c. Understands the relationship of one's own unit to larger units within the Navy.

16. Concern for Image:

- a. Emphasizes the importance of one's role as a leader/manager.
- b. Shows concern about the reputation of self, unit, or specialty, within one's professional community.

APPENDIX E

Psychiatry Interview Format

Preparation:

Review all supporting documents:

- medical record
- psychiatric questionnaire
- service record
- flight training record
- statement from command regarding performance
- consult - note the specific question asked of the psychiatrist

Discuss confidentiality issues:

- inform the patient that a written report will be placed in the medical record, but that you will try to avoid highly sensitive information
- you may inform the CO about pertinent history, diagnosis, aeromedical disposition, treatment plan, and risk for suicide and homicide
- you may violate confidentiality in certain situations, including:
 - suicidal patient
 - homicidal patient
 - violations of the UCMJ (example, illicit drug use)
 - child abuse by the patient (sexual, physical, emotional)

Interview format:

1. Identifying information:

- age
- marital status
- sex
- rank
- years in service
- command

2. History of present illness:

- symptom - explore the most likely diagnosis
- when symptom began
- what has made the symptom worse and improved
- underlying stresses (financial, romantic, job, etc.)
- how the symptom has affected the patient's social, occupational, and marital functioning
- consult DSM-IV to ask about specific criteria to support a certain diagnosis
- always inquire about suicidal and homicidal ideation
- ask questions to rule out other diagnoses

3. Past mental health treatment:
 - dates of treatment
 - presenting symptoms and diagnoses
 - type of therapy or counseling
 - medications (name, dose, duration of treatment)
 - how the symptoms affected the patient

4. Substance use history:
 - explore DSM-IV criteria for abuse or dependence for both alcohol and drugs (including illicit, prescription, and over-the-counter)
 - alcohol - consider the CAGE criteria:
 - Cut down
 - Annoy
 - Guilt
 - Eye opener

5. Medical history:
 - current or chronic medical conditions (ask about seizures, cardiac disease and arrhythmias, liver disease, and asthma, especially if planning to prescribe psychotropic medications)
 - medications (prescribed, over-the-counter, health food store item)
 - surgeries
 - head injuries (any sequelae regarding seizures, personality change, memory or concentration difficulties)
 - drug allergies
 - nicotine use (cigarettes, cigars, chewing tobacco)
 - caffeine use
 - other injuries (bone fractures)
 - if planning to prescribe medication for females - ask about fertility status, contraception use, regularity of menses, symptoms of pregnancy

6. Background (social) history:
 - where born and raised
 - developmental milestones, if known (age of walking, talking, etc.)
 - number of moves during childhood and how this affected the patient
 - father - occupation, current and past relationship with the patient
 - mother - occupation, current and past relationship with the patient
 - family history of psychiatric illness (alcohol or drug abuse, depression, psychosis, anxiety disorder symptoms, mania, suicidal ideation, attempts, or gestures)
 - any abuse of the patient - emotional, physical, sexual

- school - last grade completed, grades, extracurricular activities, disciplinary problems, social relationships
 - hobbies
 - religious interest and involvement
 - romantic relationships - duration and quality
 - marriages - number, quality, reason for divorce or separation, spouse's occupation, any abuse
 - children - ages, disciplinary problems, how are the kids disciplined (any evidence of emotional, physical, or sexual abuse)
 - civilian job performance - number of jobs, duration of each job, why left each job
 - military performance - disciplinary problems (Captain's Mast, XO, Office Hours, counseling chits), performance evaluations, career goals, accomplishments, relationships to peers and superiors
 - friendships - number of close friends, quality
 - future aspirations
 - evidence to support any personality disorders or maladaptive personality traits (poor frustration tolerance, interpersonal difficulties, job difficulties, conflicts with authority figures)
 - personality - as viewed by both the patient and others
7. Motivation for flying:
- how and when interest first developed
 - building of airplane models, attendance at airshows, reading about aviation
 - motivation for flying (image of aviator versus genuine interest in flying)
 - prior aviation experience (as passenger, as pilot or copilot)
 - type of aircraft that the patient desires to fly
 - participation by friends and relatives in flying
8. Mental status exam:
- level of consciousness (alertness)
 - interaction with the interviewer (cooperative, eye contact)
 - appearance - grooming, neatness and cleanliness of uniform or cloth
 - speech - volume, rate, rhythm
 - motor activity - (example, agitated or retarded)
 - mood - how the patient describes how he feels
 - affect - how the patient appears to feel to the examiner, appropriateness (is the affect congruent with, or does it match, the thoughts expressed by the patient), and range (full, restricted, blunted, flat)
 - thought process (logical, coherent, goal directed?)
 - thought content - predominant theme, evidence of psychosis (delusions, hallucinations, illusions, etc.)

- insight - does the patient understand how he appears, how he acts, his impact on others, and his responsibility for his actions
- impulse control
- social judgment - what would you do if you found a stamped, addressed letter?
- presence of suicidal and homicidal ideation (method, intent, means)
- cognition:
 - orientation - to person, place, time(date), situation
 - immediate recall - repeat three objects supplied by the examiner (red telephone, 52 Park Place, brown taxicab)
 - concentration - repeat digits forward (start with 4 digits, and keep adding one number until the patient cannot repeat the digit string after two tries); repeat digits backwards (start with three digits and keep adding one number until the patient misses after two tries); if the patient cannot perform the digit recall, ask him to spell "WORLD" forwards and backwards
 - recent memory - ask the patient to repeat the three words above after waiting at least five minutes
 - calculations - simple addition, subtraction, multiplication, serial 7s (subtract 7 from 100 in a serial manner; if unable - subtract 3 from 100 serially)
 - abstraction ability - proverb interpretation ("people in glass houses should not throw stones"), opposites ("what is the opposite of day?")
 - intelligence - knowledge of current events, Presidents ("name the last five"), knowledge of world events, assess vocabulary

9. Conclusion:

- does the patient have any other concerns or information that he wishes to share with the examiner?
- does the patient have any questions?
- what does the patient want ? (expected outcome of the interview)

ADMINISTRATIVE PSYCHIATRY

LEARNING OBJECTIVE: Become familiar with the various types of medical boards and other administrative procedures.

I. INTRODUCTION

If psychiatry is viewed as behavioral medicine, then it follows that psychiatry will often be involved in the disposition of behavioral problems in the service. The flight surgeon must be aware of the importance of current directives in aviation, administrative, and medical dispositions. The prudent Flight Surgeon may use readily available sources of reliable information in order to suggest appropriate dispositions in accordance with current directives.

II. OVERVIEW OF THE DIRECTIVES SYSTEM

- A. Rules and regulations encompass so many aspects of military life that every active duty member is affected by them every time (s)he is evaluated or treated.
- B. Often, administrative issues are at least as complex as the clinical issues.
- C. A competent Flight Surgeon must be proficient in administrative as well as clinical skills.
- D. To master the administrative aspects of clinical practice, one must be aware of the content and relevance of specific current directives.
- E. No single source offers this information, and the sheer quantity of regulations makes the task impossible for the average clinician.
 - 1. A 1983 survey found that the consolidated subject index alone listed 6,294 instructions issued by 25 subdivisions of the Navy.
 - 2. A survey of the change transmittal sheets issued by the Navy Publication and Printing Service for the year ending 1 October 1982 showed that there were 514 new instructions, 122 new notices, and 112 changes to existing instructions.

3. The task becomes even more complex when the need to identify Marine Corps, Coast Guard, Army, and Air Force regulations is taken into account.
- F. The Directives System, with its frequent changes, can be compared to a motion picture film, with a particular list representing just one frame.
- G. In summary, the task is to know which directives are currently applicable to a specific disposition.
- H. An Administrative Index for Mental Health Professionals, a 1983 project to provide Navy mental health professionals with a current, cross-indexed listing of all references for Navy, Marine Corps, and Coast Guard regulations pertaining to mental health, is used as a teaching aid at this point to demonstrate the volume of directives pertaining to mental health.

III. GENERAL PRINCIPLES OF ADMINISTRATIVE PSYCHIATRY

- A. Psychiatric dispositions should be made in accordance with current selection, retention, and separation criteria.
- B. For general duty, general requirements must be met.
- C. For special duty (including aviation), both general and special requirements must be met.
- D. When behavior violates regulations, psychiatry may become involved in the disposition.
 1. Psychiatric consultation may be requested for diagnosis, treatment, and disposition of a compensable mental disorder.
 2. Psychiatric consultation may be requested to determine the absence of a compensable mental disorder before a member is processed for administrative separation.
 3. Psychiatric consultation may be requested to facilitate various legal processes.
- E. Generally, there are three common reasons for selecting dispositions.
 1. Medical - A person has a medical condition which renders him/her unfit to continue to perform duties effectively or safely.
 2. Administrative - A person has a pattern of behavior or other unusual circumstance that is a burden to the Navy.

3. Special Duty - To clarify a physical status for special assignments, such as aviation, or to continue in a special designation.

IV. ADMINISTRATIVE DISPOSITION

- A. Performance and conduct are key factors influencing administrative separation decisions.
- B. Individuals must be counseled and provided with an opportunity to correct deficiencies prior to initiating administrative separations in the areas where performance and/or conduct form the basis for separation, as documented in the member's record. NAVMILPERSCOMINST 1910.1D currently governs administrative discharges.
 1. It requires the commands to expend every effort, via counseling, education, and discipline, to salvage an individual whose performance may be defective.
 2. Administrative dispositions should be invoked when a command has exhausted resources mentioned above, or when the individual becomes a burden and drain on the command resources equal to the burden of administrative processing.
 3. Commands are instructed to use rapid compliance with the processing of administrative separations only after all legal charges have been resolved.
 4. If an individual has served six years, he or she has a right to an Administrative Field Board, at which he or she may be represented by counsel in his/her own defense as a part of the separation process.
 5. Some formal reasons for administrative separation are listed. (Check current MILPERSMAN Articles and associated instructions):
 - a. Expiration of service obligation
 - b. Selected changes in service obligation
 - c. Convenience of the government
 - d. Defective enlistments
 - e. Fraudulent enlistment
 - f. Entry-level performance or conduct problems (1st 6 months).
 - g. Unsatisfactory performance
 - h. Homosexuality
 - i. Drug abuse rehabilitation failure
 - j. Alcohol abuse rehabilitation failure
 - k. Misconduct
 - l. Separation in lieu of trial by courts martial
 - m. Security

- n. Unsatisfactory participation in Ready Reserve
- o. Separation in the best interest of the service

D. Convenience of the Government specifically includes:

- 1. Personality Disorder
- 2. Parenthood
- 3. Obesity

E. Confusion often arises over the reasons for discharge versus the type of discharge. There are only five types of discharge.

- 1. Honorable discharge
- 2. General discharge
- 3. Discharge under conditions other than honorable
- 4. Bad conduct discharge (must be at the direction of a courts martial)
- 5. Dishonorable discharge (must also be at the direction of a courts martial)

V. AVIATION DISPOSITION (SPECIAL DUTY)

- A. An individual Unfit for military service is also Not Physically Qualified for aviation, but one may be Not Physically Qualified for aviation, and still be Physically Qualified (Fit) for general military service.
- B. Therefore, to qualify for aviation duty, one must be fit for full duty.
- C. The function of the Medical Board is to return the patient to full or limited duty, if warranted. If the Medical Board (or consultant) decides that the patient is fit for full duty, they should so state. The question of special duty must be separately addressed by those who have received special training. In the case of aeronautically designated personnel, MANMED 15-67 places the responsibility for flight status determination on the shoulders of the Flight Surgeon. If the patient is placed on limited duty, even the patient's Flight Surgeon cannot return the patient to flight status.
- D. Local Board of Flight Surgeons: Held by at least three Flight Surgeons at the patient's local Command.
- E. Special Board of Flight Surgeons: Held at NAMI.
- F. Senior Board of Flight Surgeons: Held at BUMED.

VI. MEDICAL DISPOSITION - MANMED, CHAPTER 18 - 7/32

A. Nine reasons for Medical Boards

1. Physical defect which precludes military service.
2. Military service will aggravate an existing physical problem.
3. Long hospitalization or intense medical supervision is required.
4. Condition is temporarily incompatible with unrestricted duty but full recovery is anticipated.
5. Ultimate recovery is uncertain, and a period of evaluation is desirable.
6. Condition requires geographic or other limitations of assignment.
7. Mental competency is in question.
8. Patient refuses indicated treatment.
9. A condition likely to recur needs to be formally documented.

B. Three Medical Board dispositions are possible.

1. Fit for full duty.
2. Fit for limited duty.
3. Referral to the Physical Evaluation Board (PEB)

C. The Central Physical Evaluation Board determines the following:

1. EPTE vs. DNEPTE
2. Line of duty vs. misconduct
3. Disabling compensable disorder
4. Disability rating

D. The Temporary Duty Retired List - TDRL's usually re-evaluated by the specialty clinic.

E. Appeals - Everyone who receives a medical board should be encouraged to write a rebuttal if they have a legitimate case.

VII. SECNAVINST 1900.9D IS REVIEWED TO ILLUSTRATE THE APPLICATION OF A CURRENT DIRECTIVE.

VIII. RELIABLE SOURCES OF INFORMATION FOR APPLICATION OF CURRENT DIRECTIVES

- A. Administrative Officer
- B. Legal Officer
- C. Fellow flight surgeons

D. NAMI

E. Other

IX. THE BOXER LAW

ANXIETY DISORDERS

LEARNING OBJECTIVE: Describe the symptoms, appropriate management and aeromedical disposition of Anxiety Disorders.

CASE EXAMPLE

A 22 y/o Student Naval Aviator tells you she is having moments when she feels "panicky". Recently these episodes occurred during a FAM flight and in the simulator, but they have also occurred at restaurants and in malls. She describes feeling anxious and lightheaded, associated with a "need for more air" and chest tightness. The episodes last about 10-15 minutes.

I. INTRODUCTION

A. *The "age of anxiety" (W. H. Auden)*

1. World-wide, there is an increasing pharmacologic effort to treat all feelings of anxiety. Large numbers of anti-anxiety agents or tranquilizers make them consistently in the top 3 in sales volume in this country.
2. Recent epidemiologic studies reveal anxiety disorders are found in all cultures. Generally, 2-4% of the population have a diagnosable anxiety disorder at any one time.

B. *Biochemical Aspects of Anxiety*

1. Locus Ceruleus Hyperactivity
2. Decreased GABA levels may cause CNS hyperactivity

C. *Differentiating anxiety from fear*

1. Fear is a natural response to a real external danger. It is a protective mechanism in both humans and other mammals.

2. Anxiety is a pathological state characterized by a feeling of dread accompanied by somatic signs indicative of a hyperactive autonomic nervous system (fear without a sound reason).

II. THE CURRENT DIAGNOSTIC CLASSIFICATIONS - DSM-IV

- A. Panic Disorder
 1. Uncomplicated - without Agoraphobia
 2. With Agoraphobia
- B. Agoraphobia without History of Panic Disorder
- C. Social Phobia
- D. Specific Phobia
- E. Generalized Anxiety Disorder
- F. Obsessive - Compulsive Disorder
- G. Post Traumatic Stress Disorder
- H. Acute Stress Disorder
- I. Anxiety Disorder Not Otherwise Specified

III. NECESSARY CLINICAL INFORMATION TO EVALUATE ANXIETY

- A. Current and past history of anxiety
- B. Feelings of derealization, depersonalization, or emotional numbing
- C. Fears of losing control or going crazy
- D. Sleep disturbance, bad dreams
- E. Medical Illnesses
- F. Physical symptoms
- G. Previous and current psychiatric illness
- H. Current medications and abused substances

- I. Current or past traumatic events or stress
 - J. Compulsive behavior or rituals
 - K. Obsessive, intrusive thoughts
 - L. Phobic fears and the context within which they occur
- IV. MANIFESTATIONS OF THE VARIOUS ANXIETY DISORDERS AS CONTAINED IN DSM-IV

A. PANIC DISORDER

1. Recurrent unexpected Panic attacks:

A discrete period of intense fear or discomfort associated with symptoms (such as tachycardia, sweating, trembling, flushing, chest pain, shortness of breath, and fear of losing control or dying) which developed abruptly and peak within 10 minutes.

2. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
- (a) Persistent concern about having additional attacks
 - (b) Worry about the implications or consequences of attack
 - (c) A significant change in behavior related to the attacks
3. Agoraphobia (May occur with Panic Disorder or alone)
- a. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a panic attack. Such situations are avoided or endured with marked distress.
 - b. Examples of agoraphobic fears include standing in line; being in a crowd; and traveling in a bus, car, airplane or train.
4. Aeromedical Disposition. Panic disorder is NPQ for aviation duty and usually for general duty. If the patient receives a limited duty board and is successfully treated, a waiver for aviation may be requested when the patient has been off medications, asymptomatic and out of active treatment for one year.

B. SOCIAL PHOBIA

1. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or scrutiny by others. The individual fears that (s)he will show anxiety or act in a way that will be humiliating. A good example is public speaking or performing.
2. Exposure to the feared social situation provokes anxiety, sometimes in the form of a panic attack. The person recognizes the fear as unreasonable or excessive. The social situations are avoided or endured with intense anxiety, and this interferes with the individual's functioning, or there is marked distress.
3. Aeromedical Disposition. Social phobias may be NPQ depending upon the amount of impairment, particularly if training or aviation safety are impacted.

C. *SPECIFIC PHOBIA*

1. Quite common - Marked persistent excessive or unreasonable fear, cued by the presence or anticipation of a specific object or situation (animals, heights, storms, seeing blood, injections, etc.) Exposure provokes an immediate anxiety response, which may take the form of a panic attack.
2. Many people have specific phobias but are able to avoid the situation or the phobic object and have no problems.
3. Interestingly, some pilots have a fear of heights but this is not bothersome in an airplane. It is not correlated to "fear of flying".
4. Aeromedical Disposition. Specific phobias are NPQ only if training or safety are impacted.

D. *OBSESSIVE COMPULSIVE DISORDER*

1. Manifested by: Recurrent intrusive ideas, impulses, thoughts (obsessions), or patterns of behavior (compulsions) that are ego-alien and produce anxiety if resisted.
2. The obsessions or compulsions cause marked distress, consume more than one hour time/day, or significantly interfere with the person's normal routine,

occupational functioning, or usual social activities or relationships with others.

3. Aeromedical Disposition: Obsessive compulsive disorder is NPQ for aviation duties and for general duty. If treated it must be under the auspices of a Limited Duty Board. A waiver may be requested when the patient is asymptomatic, out of active treatment and off medications for one year.

E. POST TRAUMATIC STRESS DISORDER

1. A person has been exposed to a traumatic event in which both of the following were present:
 - a. the person witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - b. the person's response involved intense fear, helplessness, or horror.
2. The traumatic event is persistently re-experienced in at least one of the following ways:
 - a. Recurrent and intrusive distressing recollections of the event.
 - b. Recurrent distressing dreams of the event.
 - c. Acting or feeling as if the traumatic event were recurring
 - d. Intense psychological distress at exposure to cues that symbolize or resemble the traumatic event.
 - e. Physiological reactivity on exposure to cues that symbolize or resemble an aspect of the traumatic event.
3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by at least three of the following:
 - a. Efforts to avoid thoughts or feelings associated with the trauma.
 - b. Efforts to avoid activities, places or people that arouse recollections of the trauma.
 - c. Inability to recall an important aspect of the Trauma.
 - d. Markedly diminished interest in significant activities.
 - e. Feelings of detachment or estrangement from others.
 - f. Restricted affect.
 - g. Sense of a "shortened" future.

4. Increased arousal (not present before the trauma) as indicated by at least two of the following:
 - a. Insomnia
 - b. Irritability or anger outbursts
 - c. Difficulty concentrating
 - d. Hypervigilance
 - e. Exaggerated startle response
5. Duration of the symptoms for at least one month.
6. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
7. SETTINGS IN WHICH PTSD MAY OCCUR
 - a. Combat
 - b. Maritime Disasters (Collisions at sea) or Aircraft mishaps.
 - c. Man-made disasters such as fires, explosions, train wrecks, or automobile wrecks or airline crashes.
 - d. Personal Assault such as rape, attempted murder, kidnapping, group assaults (outraged workers who return to commit multiple murders at their workplace, etc).
 - e. Natural Disasters such as tornadoes or earthquakes.
 - f. Random violence (drive-by shooting, street assaults, "carjackings", etc.) which the patient experiences.
 - g. The presence of physical, sexual or emotional abuse that occurs when one is raised in a disturbed family or family impacted by alcohol or substance abuse.
8. Pathology of traumatic events - It is now generally accepted that emotional trauma in the proper magnitude or individual setting can precipitate symptoms of PTSD in almost anyone.
9. Delay in presentation - present studies indicate that symptoms can arise as quickly as six months after the traumatic event. Two recent studies indicate that some surviving World War II veterans indeed suffer symptoms suggestive of PTSD that had been heretofore unrecognized or unrevealed. Many patients, as a general rule, continue to suppress or individually cope with post traumatic syndrome with the fear that revelation of this symptomatology will lead to a

diagnosis of being "crazy". Patients who present with a puzzling refractory mental disorder characterized by a polymorphous rage, appearance of depression, substance abuse, anxiety and somatization should raise the suspicion of a masked PTSD.

10. Aeromedical Disposition: PTSD is NPQ for aviation. Treatment should be under the auspices of a Limited Duty Board. A waiver can be requested if the patient remains off medications, asymptomatic and out of active treatment for at least one year.

F. ACUTE STRESS DISORDER:

1. Symptomatology is similar to PTSD, but the symptoms last a maximum of 4 weeks and occur within 4 weeks of the traumatic experience.
2. Aeromedical Disposition: NPQ for aviation. Waivers are handled on a case-by-case basis, but may be considered when the patient is asymptomatic, off medications and out of active treatment for six months. Contact NAMI Psychiatry to discuss the individual case.

G. GENERALIZED ANXIETY DISORDER

1. Diagnostic Criteria - Individuals with this disorder have excessive anxiety and worry that they find difficult to control about a number of events or activities. The anxiety and worry are associated with at least three of the following symptoms:
 - a. Restlessness, feeling "keyed up"
 - b. Being easily fatigued
 - c. Difficulty concentrating or mind going blank
 - d. Irritability
 - e. Muscle tension
 - f. Sleep disturbance
2. The anxiety lasts for six months or longer
3. It is mandatory to differentiate this condition from:
 - a. Agitation - as previously noted, it is extremely important to differentiate the agitated depression from the anxiety patient.
 - b. Medical conditions which can have anxiety-like symptoms such as:
 - 1) hyperthyroidism
 - 2) pheochromocytoma

- 3) Meniere's syndrome
 - 4) Caffeinism
 - 5) Alcohol withdrawal
 - 6) Stimulant intoxication
 - 7) Cardiac Disease
- c. It is to be noted that most patients with anxiety symptoms initially present complaining of physical problems and want treatment for what they consider a physical condition.
4. Aeromedical Disposition: Generalized anxiety is NPQ for aviation and usually for general duty. It may be treated under the auspices of a limited duty board, and a waiver may be requested after the patient has been off medications, asymptomatic and out of active treatment for one year.

V. TREATMENT CONSIDERATIONS

A. PANIC DISORDER

- 1. Cognitive-behavioral Therapy is quite effective alone or in combination with psychopharmacologic treatment.
- 2. Psychopharmacology:
 - a. Benzodiazepines offer good relief, but may require longterm use with withdrawal discomforts.
 - b. MAO Inhibitors - very effective - dietary restrictions make them unpopular.
 - c. SSRIs are effective but started at lower doses. Tricyclic antidepressants may have an initial "worsening" effect but are helpful for long-term use.

B. GENERALIZED ANXIETY DISORDERS

- 1. Commonly treatment involves use of benzodiazepines and behavioral therapy.

C. SOCIAL PHOBIA

- 1. Beta blockers such as Propranolol have been extremely effective and are frequently used by patients prior to a performance situation, such as a speech.

D. SPECIFIC PHOBIA

- 1. Initially, a behavioral approach with a desensitization component should be used in treating this type of phobia. Actually, most patients don't seek treatment

unless it interferes with their functioning in some manner.

E. *OBSESSIVE COMPULSIVE DISORDER*

1. Behavior Modification therapy, including group therapy.
2. Medications - Anafranil, Prozac and Luvox are now the drugs of choice.

F. *POST TRAUMATIC STRESS DISORDER*

1. Group therapy is most helpful, as well as desensitization and individual therapy.
2. Antidepressant Medications may help with depression, anxiety or insomnia symptoms.

CONSULTATION LIAISON AND OTHER PSYCHIATRIC DISORDERS

LEARNING OBJECTIVE: Describe and discuss various physiological processes that may mimic mental illness and mental illnesses not previously discussed and their aeromedical disposition.

I. OVERVIEW

- A. Establishing a good relationship with medical specialists in your geographical area and at NAMI can be critical to your ability to provide optimal health care to your squadron(s).
 - 1. Visit your available medical resources soon after arrival at your new billet. People are more responsive to someone they have met. It is your responsibility to be aware of the services offered so as to effectively advise your C.O.
 - 2. CAVEATS OF CONSULTATION:
 - a. Always provide as much information as possible to your consultants in a legible manner.
 - b. DON'T ask for consultation on a patient you haven't yet seen!
 - c. DON'T have your corpsman write the consult.
 - d. DON'T mark a consult "Emergency" or "72 hour" if it's not medically warranted, simply to impress your squadron C.O.

II. PSYCHIATRIC RESOURCES

A. *Local Mental Health Facilities*

- 1. Utilize when available. Be aware that Army and Air Force aviation standards are different, so check Navy regulations before giving an up chit. Utilize the Psychiatric Standards for Naval Aviation, a reference guide for disposition.

2. Mental Health personnel who are not Flight Surgeons cannot make PQ and AA statements. Many of them have no concept of the rigors of flight. You are responsible for decisions about flight status.
3. NAMI Psychiatry is available as a phone resource if you have specific questions about aviation psychiatric problems. Specific cases are accepted for evaluation by NAMI Psychiatry, and these are arranged on an individual basis.

III. ORGANIC ILLNESSES PRESENTING AS MENTAL ILLNESS

It is vitally important for physicians to understand the importance of performing a complete diagnostic medical assessment prior to obtaining psychiatric consultation. Many medical conditions, some life threatening, present initially with psychiatric symptoms.

A. PHARMACOLOGIC

1. Steroids - depression, psychosis
2. Antabuse - psychosis
3. B-Blockers - depression
4. Cardiac conduction agents - psychosis
5. Anticholinergics - psychosis
6. Oral contraceptives - depression
7. Indomethacin - depression, psychosis
8. INH - psychosis
9. Cimetidine - depression, psychosis
10. Caffeine - anxiety, psychosis

B. INFECTIOUS

1. HIV
2. TB
3. Syphilis
4. Hepatitis
5. Meningitis
6. Influenza

C. ENDOCRINE

1. Hypo/hyperthyroidism
2. Cushing's Disease
3. Addison's Disease
4. Hyperparathyroidism
5. Postpartum Depression/psychosis

D. COLLAGEN

1. SLE
2. Rheumatoid Arthritis

E. NEUROLOGIC

1. Multiple Sclerosis
2. Parkinson's Disease
3. Head trauma
4. Complex partial seizures
5. Cerebral tumors
6. Dementing diseases in early stages

F. NUTRITIONAL

Vitamin Deficiencies - B12, Folate, Niacin, Thiamine, Electrolyte deficiencies including calcium, magnesium, phosphates, glucose

G. NEOPLASTIC

1. Primary tumors
2. Metastatic tumors (breast, lung)
3. Carcinomatosis

H. SUBSTANCE ABUSE

Always check a blood alcohol level and urine drug screen when available.

IV. DISPOSITION OF LESS COMMON PSYCHIATRIC DISORDERS

A. EATING DISORDERS

Anorexia, Bulimia and Eating Disorder NOS are all considered NPQ. However, a waiver can be considered if there is adequate documentation of treatment and patient has been asymptomatic, off medications and out of active treatment for at least a year. Realize, however, that these disorders are extremely difficult to treat without intensive long-term psychotherapy due to recidivism. Currently these patients may be administratively separated.

B. SEXUAL DISORDERS

Sexual Dysfunctions (sexual arousal/desire/orgasm disorders) generally do not impact aviation performance and are PQ. Paraphilias (exhibitionism, voyeurism, transvestic

fetishism, etc.) are generally NPQ because such patients exhibit compulsive behavior, impaired judgment and poor impulse control. Frequently, administrative disposition takes precedence.

C. *IMPULSE CONTROL DISORDERS*

(Kleptomania, gambling, intermittent explosive disorder, pyromania, etc.) These disorders are NPQ for aviation, unless they are isolated incidents occurring in the context of Adjustment Disorder or other Axis I diagnoses. Frequently, administrative disposition takes precedence.

D. *OBESITY*

This is not a psychiatric diagnosis, nor is compulsive overeating. If the patient has Psychological Factors Affecting Physical Condition and Obesity, they are NPQ until both resolve.

E. *V CODES*

1. Relational Problems
2. Occupational Problem
3. Problems Related to Abuse or Neglect
4. Phase of Life Problem
5. Bereavement

The patient may require short-term grounding during the acute phase. These problems are all considered PQ unless there is significant impairment requiring prolonged grounding, or treatment becomes necessary. Axis I or II diagnosis should then be considered.

F. *SOMATOFORM DISORDERS*

Somatoform Disorders (Somatization Disorder, Conversion Disorder, Pain Disorder, Hypochondriasis, Body Dysmorphic Disorder) are considered NPQ. These Disorders generally require long-term treatment and waivers are generally not considered.

G. *DISSOCIATIVE DISORDERS*

Dissociative Disorders (Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder (formerly Multiple Personality Disorder), and Depersonalization Disorder) are NPQ. These disorders generally require long-term treatment and waivers are generally not considered.

PSYCHOPHARMACOLOGY

LEARNING OBJECTIVE: Become familiar with the various psychopharmacological agents, their uses and the significance of their usage in operational medicine.

I. OVERVIEW

- A. A basic understanding of each of the psychotropic drug groups is necessary and should include:
1. General indications
 2. Contraindications
 3. Mechanisms of action and properties
 4. Complications or side effects
- B. Categorized into three groups - Be familiar with 2 drugs in each group, preferably each from a different sub-group or family.
1. Antipsychotic i.e. Haldol - Thorazine
 2. Antidepressant i.e. Desipramine - Prozac
 3. Antianxiety i.e. Librium - Xanax

II. ANTIPSYCHOTIC MEDICATION

A. *Mechanisms of Action*

1. Dopamine hypothesis - mechanism of action by blocking postsynaptic dopamine receptor sites in the CNS. The critical area of action is thought to be the synaptic cleft.

B. *Classification*

1. Phenothiazines
 - a. Thorazine (Chlorpromazine)
 - b. Mellaril (Thioridazine)
 - c. Stelazine (Trifluoperazine)
 - d. Prolixin (Fluphenazine)
2. Butyrophenone
 - a. Haldol (Haloperidol)
 - b. Droperidol
3. Thioxanthenes
 - a. Navane (Thiothixene)

4. Clozaril (Clozapine) is a new anti-psychotic that is marketed as an optional medication for treatment resistant schizophrenics. Risperdal (Risperidone) is an even newer antipsychotic which is presumed to be a first-line serotonin/dopamine antagonist. Currently these medications are not available to the flight surgeon.

C. Properties and side effects tend to differentiate these medications more so than clinical response.

1. Sedative - common in all, more so in low potency forms (ex. Thorazine, Mellaril). Tolerance develops rapidly in most cases.
2. Extrapyrimal reactions such as dystonias, akinesia, akathisia and parkinson-like syndromes. Tardive dyskinesia is especially serious.
3. Orthostatic Hypotension - most common with low potency forms.
4. Anticholinergic - most common with Mellaril
5. Differences in high potency (ex. Haldol) and low potency - less sedation and hypotension in high potency drugs but a greater incidence of extrapyramidal reactions. High potency drugs tend to be less anticholinergic.
6. Exposure to excessive sun rays and hot or warm spaces with no air conditioning must be prevented.

D. Administration

1. Oral - Tablet. Liquid form for some types (Haldol)
2. I.M. - all except Mellaril
3. Depot Administration - Prolixin - Haldol
4. Rapid Tranquilization - two approaches are common - high dose at long intervals or smaller doses at short intervals to "titrate" response. The latter approach is becoming more accepted.
 - a. Rationale and indications - use only to control behavior otherwise uncontrollable - try to avoid sedation to the point that the patient is unable to cooperate in a history or mental status exam.
 - b. Diagnosis - pursue evaluation and try to exclude organic cause.
 - c. Appropriate drugs to use.

- 1) Haldol-2 mg IM every 30 minutes until calm or 5 mg QIH until calm. Recommended maximum is 60 mg in 24 hours.
 - 2) Thorazine-100 mg po or 50 mg IM QIH until calm. Recommended maximum is 800 mg in 24 hours.
5. Once-daily dosage usually at bedtime is the most convenient schedule once patient has stabilized. A good place to start is about 1/2 of the total tranquilizing dose used initially.

E. Toxic or Idiosyncratic Reaction

1. Agranulocytosis - most common in high dose medications
 - a. Rare - usually first 8 weeks - 1 in 4,000 patients
 - b. First symptom - fever and sore throat
 - c. Motility rate 30%
2. Cholestatic Jaundice
 - a. Incidence - 1 in 10,000
 - b. Withdraw drug - may use another
3. Ophthalmologic Changes
 - a. Deposits in lens and cornea - high dose Thorazine
 - b. Retinopathy with Mellaril > 800 mgm
4. Photosensitivity - primarily with Thorazine
5. Neuroleptic Malignant Syndrome - confusion - fever - tachycardia - high CPK - sometimes treated with Dantrolene - if not properly managed, may be lethal.

F. Side Effects

1. Adrenergic - increased pulse and hypotension - Primarily in low potency drugs
2. Anticholinergic - Primarily in low potency drugs
3. Sedation - primarily low potency drugs
4. Seizures - lowers seizure threshold - more common in Thorazine and other low potency drugs
5. EKG changes
 - a. T-wave inversion
 - b. Prolongation of Q-T interval
 - c. Mellaril is the major offender in EKG changes
6. Extra-Pyramidal Symptoms - more common with high potency drugs
 - a. Pseudoparkinsonism

- 1) Akinesia - muscle "stiffness" produces "shuffle gait" moving about.
 - 2) Rigidity of skeletal muscles (cogwheeling)
 - 3) Tremor - may be pronounced in some patients.
- b. Akathisia - motor restlessness and anxiety.
- 1) May occur with only 1 mg of Haldol
 - 2) If patient has a history of violence, be cautious about inducing akathisia
 - 3) Symptoms may be confused with worsening psychosis
 - 4) Treatment - decrease dose, anti-parkinson agents, Propanolol, Xanax
- c. Dystonic Reaction
- 1) Include Dyskinesia and oculogyric crisis
 - 2) Rapid treatment - Cogentin, Valium, Benadryl, IV route is effective in minutes
- d. Tardive Dyskinesia
- 1) Manifested by abnormal, involuntary choreoathetoid movements of tongue, lips, jaw, face extremities and trunk
 - 2) Incidence - 3% per year of exposure onset after 3 to 6 months of administration
 - 3) Treatment - consider discontinuing the drug. Benzodiazepines may help. Refer to a psychiatric center that specializes in tardive dyskinesia

III. ANTIDEPRESSANTS

When appropriately used, these medications can manage the vast majority of depressive syndromes. New antidepressants are being brought onto the market rapidly, but the "tried and true" are still effective.

- A. **Stimulants** - amphetamines - primarily historical interest but occasionally used in research, geriatric and "difficult" cases
- B. **Tricyclics** - (now commonly called heterocyclics)
1. Mechanism of action
 - a. Block receptors of Serotonin.
 - b. Block receptors of Norepinephrine.
 - c. Newer compounds may block Dopamine.
 - d. The mechanism of action as well as side effects may differentiate drugs.
 - e. Therapeutic window - serum level at which clinical response is maximum.
 - 1) Primarily useful in Nortriptyline
 - 2) Currently being evaluated in other antidepressants.

2. Side Effects
 - a. Sedation - varies - 0 to 4+. Amitriptyline is highest. Desipramine is lowest.
 - b. Cardiac
 - 1) Conduction defects, primarily in elderly
 - 2) Major problem - overdose is the usual cause
 - c. Anticholinergic - highest with amitriptyline and lowest with Desipramine.
 - d. Autonomic
 - 1) Hypotension
 - 2) Tachycardia
 - e. Consider side effects as they may relate to each individual patient.
 - 1) Special problem - sexual dysfunction and constipation.
 - 2) Dry mouth - especially in people who must "communicate".
3. Administration
 - a. Starting dose - individualize - but usually 25 to 75 mgm and increase as side effects permit-usually every 4-7 days. Always read the PDR prior to prescribing.
 - b. Use of serum levels especially helpful at beginning of treatment - to document rise and determine absorption.
 - c. Usually maintain dose for four to six months then taper slowly.
 - d. Changing meds - if no response - use one with different mechanism of action. Thyroid supplements may sometimes help.
4. Indications
 - a. Major depressive disorder - particularly with vegetative signs.
 - b. Agoraphobia - not for anticipatory anxiety.
 - c. Combining with antipsychotic drugs in psychosis with major affective component.
 - d. Bulimia - not as sole therapy, but as an adjunct to other modalities.
 - e. Always utilize a psychiatrist's services if available for prescribing antidepressants if possible.
5. Overdosage
 - a. Major problem in treatment as many depressed patients exhibit suicidal ideation.
 - b. Cardiac toxicity with arrhythmias and arrest is the most serious and life threatening.
 - c. A secondary problem is seizures.
 - d. Treatment
 - 1) Physostigmine - consult standard protocols.
 - 2) Activated charcoal and gastric lavage up to 24 hours after initial ingestion.

6. Newer Antidepressants

- a. There is a continuing search for rapid acting drugs with low side effects.
- b. At this time, the biggest advantage of the newer drugs is the reduced side effect profile. However, all antidepressants have side effects of some type.

1) Specific names of newer drugs:

- Serotonin Reuptake Inhibitors:
 - Prozac (Fluoxetine)
 - Zoloft (Sertraline)
 - Paxil (Paroxetine)
- Serotonin/Norepinephrine Inhibitor:
 - Effexor (Venlafaxine)
 - Serzone (Nefazodone)
- Wellbutrin (Bupropion): is an "Atypical" antidepressant which works through a noradrenergic mechanism

- 2) These medications are not readily available to non-psychiatrists in the military system due to the cost difference.

C. **MAO Inhibitors (Ex. Nardil)** - The first effective antidepressants - once in disfavor now becoming more popular - previous "misinformation" is now being clarified.

1. Little used in fleet - primarily prescribed by psychiatrists - mainly due to dietary precautions and necessity for close monitoring
2. Indications
 - a. Atypical depression
 - b. Panic disorder
3. Complications can occur with ingestion of foods that contain tyramine (hypertensive crisis) or with ingestion of Demerol or asthma medications such as epinephrine
4. Major side effect- orthostatic hypotension

D. **Electroconvulsive Therapy (ECT)** - ECT may be safer than tricyclic antidepressants for some patients. Usually reserved for patients who have failed medication trials or for patients who are so acutely dangerous, depressed or suicidal that a course of pharmacotherapy might be too slow. Controversial but as effective and very useful for elderly.

E. Lithium

1. The mainstay of treatment for mania, but this medication has no place in the Fleet - requires a Medical Board for use.
2. Indications
 - a. Bipolar disorder
 - b. Unipolar disorder as an adjunct to other medications
 - c. Used on occasion to treat Intermittent Explosive Disorder and impulse problems of Borderline Personality Disorder
3. Blood levels and Toxicity - very narrow safety margin. Lithium can cause renal insufficiency, hypothyroidism, and conduction defects.
4. Administration to normal control subjects usually has no effect.

IV. ANTIANXIETY AGENTS

A. Historical Development - search for the "perfect drug"

1. Reserpine - India.
2. Tobacco - "Sot Weed".
3. Late 1800's - Barbiturates first introduced.
4. 1937 - Antihistamines.
5. 1954 - Meprobamate - very popular "tranquilizer" - widespread abuse.
6. 1960 - Benzodiazepines - Librium - still a useful drug.

B. Current Treatment - Benzodiazepines are the drugs of choice.

1. Contemporary facts concerning use
 - a. 41% of the population consider medication use a sign of "weakness".
 - b. 82% of the population feels that individuals should work out own problems.
 - c. 10% have used Benzodiazepines in the past year.
 - d. 15% of this 10% used greater than 12 months.
 - e. 85% prescribed by non-psychiatrists.
 - f. Second most prescribed drug in U.S. Xanax is the leader of the anti-anxiety agents.
2. Mechanism of Action
 - a. Enhances G.A.B.A.
 - b. New studies reveal specific receptor sites in CNS.
 - c. Reduces turnover of norepinephrine and serotonin.
 - d. Glycine effect accounts for muscle relaxation.
3. The Elimination Half-life is the most important distinction among these drugs.

- a. Long half-life: Example- diazepam (Valium).
 - 1) Tend to accumulate with repeated dosage.
 - 2) Metabolized to active ingredient (eg. desmethyl diazepam).
 - 3) Increased risk for excessive daytime sedation.
 - b. Short half-life: no active metabolite.
 - 1) Example: lorazepam (Ativan); alprazolam (Xanax)
 - 2) Produce less impairment with regular use
 - 3) Produce more severe withdrawal syndrome
4. Route of Administration
- a. Oral - all absorbed
 - b. I.M. - slow and irregular absorption (exception: Ativan)
 - c. I.V. - only available for Valium, Librium and Ativan
5. Clinical Indications and Uses
- a. Excellent drugs for anxiety disorders- Xanax is the most commonly prescribed drug for generalized anxiety disorder and in many cases panic disorder. However, the diagnosis must be correct before prescribing medication with a high addiction potential. These medications should be prescribed sparingly and under supervision for less than 2 weeks by the flight surgeon in cases of situational anxiety due to marital problems, grief, etc.
 - b. BZD's are usually used for brief periods - FDA approved to four months at this time - some studies now document close to 10 years use in some "select" patients.
 - c. Few patients require long-term therapy, and these are generally not retained on active duty
6. Withdrawal
- a. Never stop suddenly! The risk of withdrawal is real and seizures can occur. A slow taper is recommended and least likely to precipitate withdrawal.
 - b. Withdrawal Symptom complex - restlessness, tremulousness, headache, GI symptoms, seizures
 - c. Withdrawal symptoms can begin 1-2 days after stopping short acting, 4-7 days long acting
 - d. All are physiologically addicting - 5-10% will show withdrawal symptoms on therapeutic doses. A major concern when deciding on long-term therapy. The patient must be aware of the risk. Recent studies show that in spite of physiological dependence that in

non-dependency type patients there is no evidence of tolerance or increasing dosage.

- e. New treatment - Propanolol will block autonomic symptoms - use with slow tapering procedure.

7. Side Effects

- a. Sedation
- b. Impaired memory and concentration
- c. Occasional increase in aggression - (dis-inhibition) particularly in children
- d. Occasional depressive symptoms arise that may require discontinuing the drug.
- e. Increased effects when used with alcohol

8. Treatment Alternatives to antianxiety agents

- a. Antihistamines - used for sedation when use of BZD's may be a problem.
- b. Drug abusing patients - small amount of antipsychotic agents may be of value.
- c. Phobic anxiety or panic disorder - use antidepressants if anxiety is a transient symptom. Some recent evidence suggests that TCA's are quite effective in chronic anxiety.
- d. Occasional use in combination with anti-depressants.
- e. No indication for use of two benzodiazepines at the same time.

9. New Antianxiety Agents

- a. Propanolol first used in Europe - now becoming more popular for many symptoms.
 - 1) Used for performance phobia
 - 2) Give in sufficient doses to reduce pulse rate
- b. Buspirone (Buspar) - a non-controlled agent - may not be as effective as advertised, however there is a lack of sedation or interaction with alcohol. Maximum therapeutic effects are not obtained until 3-4 weeks.

C. Hypnotics

1. Always consider other sleep hygiene measures first in a patient with insomnia (refer to literature on Sleep Disorders).
2. One of the newest hypnotic agents is Ambien (Zolpidem), a non-benzodiazepine agent, typically used at a dosage of 10 mg q hs. Current studies do not reveal evidence of rebound insomnia or next-day memory impairment, and the drug has a short half-life.

3. The 3 benzodiazepines used primarily for sleep are:
 - a. Dalmane
 - b. Restoril
 - c. Halcion
4. Long Acting - primarily Dalmane (Flurazepam)
 - a. Blood levels increase with daily usage - after 8 days, 4-6 times level on first day
 - b. Some deterioration in motor tasks
 - c. Some impairment in cognitive tests - then returns to normal
 - d. Problems in flight personnel (hangover) (safety considerations)
 - e. Best dose - 15 mg
5. Short Acting - Primarily Restoril (Temazepam) and Halcion (Triazolam).
 - a. Use smaller dose - 0.25 mg Halcion, 15 mg Restoril
 - b. Occasional mild withdrawal following day - does not occur with Dalmane
 - c. Be aware that Halcion has been associated with amnestic periods after use, and multiple legal battles are ongoing
6. Antihistamines may be just as effective for short term hypnotic use (Benadryl 25-50 mg po qhs)

THE MILITARY FAMILY

LEARNING OBJECTIVE: Understand the unique stressors experienced by the military family.

I. INTRODUCTION

- A. The impact of the military family on military operations has been documented throughout history. In over 3,000 years of recorded history, only 268 have been without active warfare. Almost every generation of human civilization has encountered and had to cope with the impact of warfare and military deployment. Descriptions in Greek literature are not significantly different from descriptive scenes surrounding today's military families. The reasons for war and the reasons that individuals and families remain in the military service are vicariously interesting from the psychodynamic standpoint. A brief overview will be presented during the lecture.
- B. Pertinent current figures (1987) indicate that there are about 563,000 total active duty personnel. About 53% of all enlisted are married and about 74% of all officers are married. Approximately 8,200 families have both parents as active duty members and each day in the Navy 84,000 geographically single-parent families exist due to Navy deployments.
- C. Our modern society puts unique stressors on each and every family. The military family not only faces the stressors associated with coping with daily life, but has added unique stressors of its own. These include:
1. Frequent Geographical Moves - it is estimated that at least one third of the Navy population moves each year to a new duty station. This can be particularly stressful on children in the adolescent years and the pre-school years. In one sample study, one half of all military children move each year as compared to a civilian population in which only one fifth of the civilian population changed geographical areas. Financial burden of changing duty stations is often

significant with the average out-of-pocket costs of PCS for an officer being \$2,000.

2. Military Deployment - frequent separations and reunions often keep a household in continued flux giving a sense of instability and insecurity to all family members.
3. "The Navy is First" is a dictum that is often very hard for spouses in particular to accept. Active duty members often have to adjust their loyalty to their profession against the needs of their family.
4. Family Growth is sometimes structured to conform to the rigid and regimented military system. This particularly has impact on educational planning, spouse jobs, adding new members to the family and visits to relatives.
5. Risk of injury or death to the active duty member even during routine stateside training often generates fears and fantasies in not only the children but in the spouse also.
6. Feelings of detachment from the mainstream of society continue to occur. This can present as harsh reality in those communities that are not accepting of the military or its philosophy. Some families have a tendency to become totally involved in the military as a mechanism of security and do indeed become isolated from the daily American culture.
7. The effect of rank structure can be felt throughout a family. Social, family, and individual activities are often attended on a scale commensurate with the service member's pay grade or rank. At times this has been known to impact in school, places of employment for dependents and other social activities.
8. Lack of personal control over duty stations, leave, orders, training and deployment often leave the entire family feeling helpless.
9. Early retirement and a second career heretofore not often recognized as a significant stressor is now found to have more and more meaning as a traumatic event in an active duty service member's life, particularly in light of the Navy's "rightsizing". This may be even more meaningful if adolescent family members are required to again move to set up with the family in the

new geographical location away from the lifestyle with which they are familiar.

- D. Deployment - The concept of deployment warrants special interest. Technically, it is defined as a forward movement of a military organization closer to the field of battle. Several studies have demonstrated the impact of family separation during deployment upon not only the active duty service member but his/her family members. Studies done in San Diego have demonstrated that spouses of deployed Naval service members all experienced some subjective feelings of depression beginning two weeks prior to deployment. 50% had symptoms of a magnitude that would be compatible with an adjustment disorder with depression and a few were approaching that of major depression. Of interest also was an observation of health records in which sick call visits in children increased dramatically just prior to the sponsor leaving. The visits then resolved to a normal visitation rate and subsequently increased dramatically just prior to the sponsor returning.
- E. For a long time, it has been recognized that individuals and families undergo emotional changes during the deployment cycle. It is felt that these changes apply not only to the active duty member but to the remaining family members at home. Often the active duty member is overlooked because the frenzied activity of deployment not only occupies his/her time but helps mask the symptoms. The emotional cycle of deployment was outlined in a more formal fashion (see Proceedings, February, 1987).
1. The pre-deployment phases are noted as follows:
 - a. Stage I which occurs one to six weeks prior to actual deployment is manifested by all family members. Family members are anticipating a loss and initially rush to complete home projects and prepare for the service member's absence. There is often an increase in bickering, arguing and some initial attempts to withdraw from the emotional pain of separation.
 - b. Stage II occurs about one week prior to actual departure and is marked by increased detachment and withdrawal. A noted combination of tension and anger sometimes are prominent in the spouse, and sexual difficulties may begin to arise. This phase of the pre-deployment emotional cycle can be especially devastating if the deployment is delayed.

2. The deployment phases are noted as follows:

- a. Stage III begins immediately and lasts for about the first six weeks. Especially for spouses at this time is noted an emotional disorganization in which they may experience a gamut of feelings from relief, guilt, panic, anger, and depression. It is at this time that the actual clinical diagnosis of adjustment disorder and/or major depression can be made.
- b. Stage IV occurs about the mid-point deployment and is very often incomplete. It is a period of recovery and stabilization. In a healthy well-supported spouse, with good personality organization, it is an opportunity to cultivate new friends, develop a variable lifestyle, to make decisions on one's own, and to become independent. Many people find that this actually is very satisfying, gratifying, and utilize the opportunity to grow to the fullest.
- c. Stage V during deployment occurs just about six weeks prior to the ending and return home. It is often called the anticipation of homecoming. It again is marked, as was the pre-deployment stage, by panic, anger, feelings of a loss of independence by spouses, and feelings of anxiety about whether their spouse will accept their changes.

3. The post deployment phases are noted as follows:

- a. Stage VI occurs six weeks after return. It is a time of renegotiation of the marriage contract. It is at this time that the marriage must be reviewed, roles may need to be redefined, and the deployed members must reacquaint themselves with their spouse, children, and entire family.
- b. Stage VII occurs six to twelve weeks after return and is often called a period of reintegration and stabilization. At this point in time, the family has identified its new lifestyle, roles have been redefined and people are interacting in an acceptable fashion and the family again returns to a routine.

- F. There are several tips and techniques that can be utilized by deploying members to reduce the stress of deployment. The Flight Surgeon would do well to become familiar with an article, "When Daddy Comes Home", published by the Times Magazine, September 29, 1976. Tips on dealing with stress for personal use or counseling others are outlined, and are applicable whether "Daddy" or "Mommy" or "both" deployed.
1. The family must discuss as a unit their feelings about the upcoming separation. Anger, sadness, and fear should be clearly outlined. All family members who are able to talk, sit, or be held should attend. A tendency is often seen to exclude other than adults or teenagers. This can be extremely threatening and frightening to children as young as one year old.
 2. It is essential that the spouse keep the same rules for discipline and maintaining the household for the children while Mom/Dad is gone as they were when (s)he was at home.
 3. It is very important for the deployed parent to send separate letters to each child, preferably on a weekly basis. More technical modern means of communication include cassette tape and video tape. Younger children often find it very helpful to have a calendar in an appropriate place to mark off the days until Mom/Dad returns. Sometimes it is very useful for the deployed parent to deliver messages to the spouse via the children's letters.
 4. On returning from deployment, the deployed parent must remember that their role has been filled by the remaining family members for some period of time. (S)He has to be willing to discuss feelings on return of insecurity, anger, resentment that may result from restructuring or renegotiation of roles.
 5. Private time with the spouse is essential. There should be a period of time free from the children for the husband and wife to become reacquainted. Each child should also separately be given at least one half day of individual time and attention.
 6. For the first week, it is extremely important to exclude or avoid all other extended family members, friends, unnecessary travel, and social commitments.
 7. The immediate return from deployment tends to become bogged down with engagements, events and obligations

that leave little or no time for family interaction. This may impair the struggle to achieve comfortable roles and not allow time to renegotiate the family structure.

8. It is extremely important for all family members, in a formal family conference to be able to share their feelings and their desires and needs for the upcoming period of time that the family will be together.

G. Even more important than general needs of the family are the needs of the individual military spouse. Each partner in a marriage may have certain skills. Some spouses may feel unprepared to handle jobs such as checking the oil or changing a tire on the car. On the other hand, some spouses feel overwhelmed when left to handle all of the children's needs such as laundry, doctor's appointments, sports schedules, PTA meetings and bake sales. An alert and vigilant Flight Surgeon will be aware of the opportunities to discuss deployment preparation not only with individuals but with groups of individuals including spouses clubs and all hands meetings. The following tips and techniques not only can be used to personal advantage but also will be part of one's individual armamentarium for advice to deploying squadron mates. It is of interest to note that often the spouse feeling most estranged, most abandoned during deployment is the medical spouse. (S)he may be new to the military, younger than other squadron spouses, and often very reluctant to get involved in military life. This can be particularly true of non-military men married to active duty officers.

1. Spouses Organizations are very important. Officer and enlisted spouses are encouraged to attend, become a part, and participate. This is usually the medium by which group support is most effective and is usually strongly supported by the Commanding Officer.
2. All spouses should be aware of the Ombudsperson for that particular squadron. By Secretary of the Navy Instruction, each squadron is entitled to have a Commanding Officer appointed Ombudsperson who has direct access to the Commanding Officer to bring to his attention particular problems of spouses and other family members.
3. Families with specific medical problems should have direct access to a preferred physician prearranged. It is wise for Flight Surgeons who are about to deploy to make contact with the local dispensary and to encourage

the families to utilize Champus/Tricare and contact a local physician. It would be wise to make one visit, introduce the family and have that physician available in case illness were to occur during his/her absence.

4. A will - even when not actively engaged in warfare, deaths do occur in the military. A will ensures that the spouse will be able to transition into a new life in the event of servicemember's death with minimal legal complications.
5. An allotment to the bank for the paycheck saves the spouse concern about whether the check will arrive in the mail and guarantees a steady flow of income.
6. Power of Attorney is mandatory. In the event of disaster, perhaps even as minor as having repairs on the car, without a power of attorney the spouse may be unable to make decisions on joint property or money.
7. AAA protection for the car may seem trivial, but if the family decides to travel, it is a significant insurance to keep from getting stranded and having unnecessary difficulties. Also AAA will assist in any advice on repairs and reliable mechanics if major car trouble were to occur while the spouse is gone.
8. Service contracts on appliances remove concern from the spouse in case major appliance malfunctions occur.
9. A safe neighborhood is mandatory. If a service member is to deploy, personal safety is one of the major concerns of the spouse. On-base housing has definite advantages, especially at those bases where housing is considered appropriate and adequate. If on-base housing is not a preferred option, then certainly the most secure and reasonable neighborhood that one can afford is in order.

II. SUMMARY

The military family has tremendous impact on modern military operations. Military deployment has and will continue to be a major aspect of Navy life. Military deployment is one of the major stressors on the Navy family but there are many things that can be done to ease the burden. By understanding some of the concepts of the emotional cycle and possessing practical advice for deployment, the Flight Surgeon can ensure himself/herself greater security for his/her family and will also be able to offer advice and direction to those squadron members who may not

have the energy, wherewithal or knowledge to adequately plan ahead. Presentation of pre-deployment briefings from the standpoint of the Flight Surgeon and psychosocial aspects of deployment is encouraged at every opportunity.

FAMILY SERVICES CENTER

LEARNING OBJECTIVE: Understand the services available to the military family through the Family Services Center.

I. MISSION

The mission is to improve Navy awareness of and access to reliable and useful information, resources and services which support and enrich the lives of Navy and Marine Corps personnel and their families. Services are available to active duty military, retired personnel, and eligible family members at no cost.

II. SERVICES

A. *Counseling:* provided by trained civilian counselors. Entries are not placed in health records.

1. Individual Therapy
2. Marital Therapy
3. Family Therapy
4. Group Counseling

B. *Educational Programs:* Programs and workshops on personal and family enrichment that promote effective on-the-job performance and enable people to achieve a more satisfying life.

1. Core Programs:
 - a. Stress Management
 - b. Anger Management
 - c. Parenting Classes
 - d. Marital Relationship Classes
2. Other Programs:
 - a. Spouse Employment Assistance Program
 - b. Exceptional Family Member Support Group
 - c. Single Parent Support Group

- d. Hearts Apart (Group for geographically separated families)
- e. Transition Assistance Program

3. Family Programs:

- a. Parents and Tots Play group
- b. WIC (Women, Infant, and Children)- Supplemental food program providing formula for babies, special foods for children under five, and pregnant or breastfeeding women. Eligibility is based on nutritional risk and income.

C. Information and Referrals

- 1. Referrals to agencies on and off base.
- 2. Information about local resources such as Support Groups (AA, Grief, AIDS, OA, etc.).

II. NAVY FAMILY ADVOCACY PROGRAM (NAVMEDCOMINST 6320.11 - 19 JAN 89)

- A. The Navy Family Advocacy Program is designed to address the prevention, identification, treatment, follow-up, and reporting of child abuse and neglect and spouse abuse.
- B. Scope: The Family Advocacy program element is a coordinated effort between the Navy Military Personnel Command and The Navy Medical Command. The key organizational elements in Family Advocacy are:
 - 1. Family Service Centers tasked with prevention, education and coordination.
 - 2. Medical Treatment Facilities responsible for identifying and treating families at risk following reports of maltreatment received from the Family Advocacy Representative (FAR).
 - 3. Family Advocacy Representative who implements the medical component of Family Advocacy and coordinates all aspects of case management.
 - 4. Area Family Advocacy Committee (FAC) which coordinates the base Family Advocacy Program and consists of representatives of a broad spectrum of community organizations and is chaired by a line officer.

5. Case Review Subcommittee(s) of the Area FAC which manages and reviews individual cases.
- C. The Navy's comprehensive response to family violence is designed to prevent or to stop the abuse and to minimize its impact on the family and on the Navy. Program components include:
1. Prevention: Navy family support programs help to minimize the negative stresses caused by a mobile lifestyle.
 2. Intervention and Treatment: A multidisciplinary team of family advocacy professionals and command representatives recommends an appropriate response to identified cases of abuse. The Navy's intervention may include:
 - a. Crisis intervention
 - b. Emergency shelter
 - c. Rehabilitation or treatment to prevent abuse
 - d. Disciplinary or administrative sanctions
 - e. Criminal prosecution
 - f. Close coordination with civilian social service providers
 - g. Incest treatment option for carefully screened offenders
 - h. Physical and mental health treatment for incest survivors
 3. Case Management and Follow-up: Family Advocacy cases are monitored to ensure the victim is safe and the perpetrator is making progress. Case follow-up spans one year to allow time to resolve the immediate problem before reassigning the Service member.
- D. Special Considerations
1. Reporting: Every individual is responsible for reporting suspected and known cases of child abuse/neglect and known cases of spouse abuse to the Family Advocacy Representative. This reporting can be done through the Family Service Center or local child protective service in the case of child abuse. The FAR is responsible for notifying relevant naval and civilian authorities in family advocacy cases. The FAR, or the FSC, by delegation, notifies the servicemember's command of reports of suspected or substantiated cases of child abuse and substantiated

cases of spouse abuse, i.e., confirmed by physical evidence of testimony.

2. Overseas Issues: Lack of skilled professional expertise for the diagnosis and treatment of family violence, and large gaps in the provision of social services to families overseas or at isolated duty station, may alter the manner of disposition of family advocacy situations. For example:
 - a. In cases of child abuse/neglect, the safety of the victim is the foremost consideration and may require that the base or MTF CO remove the victim from the home. The member's CO may restrict the perpetrator to a controlled location separate from the victim.
 - b. When diagnostic or treatment needs cannot be met by local resources, transportation of the person to an appropriate treatment facility may be recommended by the FAC.
 - c. The CO may recommend return of the family to CONUS.
 - d. The Flight Surgeon should have a firm understanding of local resources, laws and cultures, and a good working relationship with the FAR.

APPENDIX L



SUICIDE PREVENTION

CDR Mark Mittauer

Why Is This Important?

- ✦ Suicide is the 3rd leading cause of death for people between age 15 and 24
- ✦ One third of Navy members are in this age group
- ✦ 10% of active duty deaths are due to suicide
- ✦ Navy: 50 to 70 deaths per year
- ✦ USMC: about 30 deaths per year



Who is at highest risk for suicide in the Navy? (long term)

- ✦ Caucasian male
- ✦ age 18 to 24
- ✦ junior enlisted (E1 to E3)
- ✦ single with no kids
- ✦ living alone (and no friends)
- ✦ on liberty and in the home or barracks
- ✦ Spring or Fall (not Christmas)



Risk Factors (cont.)

- ✦ access to firearm:
 - 50% of Navy suicides involve guns
 - gun in home of teen *doubles* his risk!
- ✦ family history of suicide in close relative
- ✦ traumatic childhood (abuse, instability)



Risk Factors (cont.)

- ✦ psychiatric illness (in 95% of suicides):
 - depression, personality disorder, psychosis
 - alcohol abuse (42% of Navy suicides have (+) BAL)
- ✦ previous suicidal behavior:
 - 50% who suicide tried before
 - most suicides within 6 months of 1st attempt
 - 90% who attempt *do not* later suicide



Acute Risk Factors for Suicide

- ✦ hopelessness
- ✦ severe sleep problems
- ✦ intolerable "psychache" (pain)
- ✦ severe anxiety
- ✦ mood swings (depression/anxiety)
- ✦ recent alcohol use
- ✦ anniversary of important loss



Acute Stresses for Suicide

- ✦ relationship problem
- ✦ change in professional/social status:
 - financial problems
 - legal action
 - poor performance evaluation



Warning Signs for Suicide

- ✦ mood changes - depression, anxiety, irritability
- ✦ social withdrawal
- ✦ increased alcohol use
- ✦ feelings of worthlessness or hopelessness
- ✦ giving away possessions
- ✦ making final arrangements (will, insurance)



How Can You Help Someone Who is at Risk for Suicide?

- ✦ Instill hope that help is available/the situation will get better
- ✦ Be a friend/don't abandon
- ✦ Help the person reduce his stress
- ✦ Supervisors - talk to your folks about their concerns, family
- ✦ Unauthorized absence:
 - search home/quarters
 - question friends and coworkers
 - call FSC, hospitals, chaplains, police



Resources

- ✦ Family Service Center:
 - stress management
 - financial counseling
 - marital counseling
 - parenting classes
- ✦ Chaplain/CREDO
- ✦ Therapy (NOMI Psychiatry; PNH)
- ✦ Navy Relief



General Ways to Reduce Suicide Risk

- ✦ Deglamorize alcohol use/suggest alternatives
- ✦ Deglamorize firearms possession/use
- ✦ Educate that mental health treatment *does not* mean your Naval career is over



What Should You Do if You Think That Someone is Suicidal?

- ✦ **ASK!!!!** the patient, family, friends
- ✦ Why ask if someone is suicidal?:
 - asking does not "plant the idea"
 - you are qualified to ask about suicide
 - the person may be relieved that you recognize how bad he feels



How Do You Ask About Suicidal Thoughts?

- ✦ “How bad do you feel?”
- ✦ “Do you wish you were dead?”
- ✦ “Tell me about your thoughts of hurting yourself?”
- ✦ “Many people in your situation think about suicide. What about you?”



What Should You Do if Someone is Suicidal?

- ✦ Do not leave him alone (bathroom)
- ✦ Do not postpone arranging help
- ✦ Do not accept a promise from the person that he will not hurt himself
- ✦ Do not promise to “keep the secret”
- ✦ Do not argue, moralize, tease, minimize
- ✦ Do not underestimate the risk if the person has made a nonlethal gesture



How to Help a Suicidal Person

- ✦ Escort the person to your supervisor, the nearest Medical Officer, or Pensacola Naval Hospital Emergency Room
- ✦ Call an ambulance or the police, if needed
- ✦ Transport to the nearest emergency room if the person has overdosed or made a serious suicide attempt



What if a Suicidal Person Calls You?

- ✦ Ask the person for his name, phone number, location, command
- ✦ Call the police or an ambulance
- ✦ Talk to the person until help arrives



Assessment Requirements

- ✦ An active duty member suspected of being suicidal **must be evaluated** by a psychiatrist, psychologist, or medical officer (if the former are not available)



Questions?



- 1 **Written Psychiatric Report**
- 2 **General Guidelines:**
 - ▲ The format is similar to a standard medical report
 - ▲ Before you write, decide the diagnosis
 - ▲ Write the report (and especially the HPI and Social History) to support the diagnosis
 - ▲ Include pertinent information and not a “blow by blow” of the interview
 - ▲ Answer the question posed by the referral source
- 3 **Identifying Information**
 - ▲ Include a statement about confidentiality
 - ▲ Note that the member consented to the interview
 - ▲ Note sources of information (example, review of the medical record, flight training record, etc.)
- 4 **History of Present Illness**
 - ▲ Include information to support your diagnosis
 - ▲ Include pertinent negatives
(example, “The patient denied having had suicidal thoughts”)
 - ▲ Discuss any previous mental health treatment
- 5 **Social History (SH)**
 - ▲ birth order
 - ▲ where born and raised
 - ▲ whether parents are still married
 - ▲ history of abuse as child
 - ▲ education
 - ▲ athletics/hobbies
 - ▲ dating/romantic history
 - ▲ friendship quality
- 6 **Social History (cont.)**
 - ▲ marriage/current romantic relationship
 - ▲ children
 - ▲ aviation motivation
 - ▲ religious interest
 - ▲ occupational history
 - ▲ military history/performance
 - ▲ family history of psychiatric illness
- 7 **Social History (cont.)**
 - ▲ evidence to support personality disorder or maladaptive personality traits (Axis II)

- ▲ alcohol use
- ▲ illicit drug use
- 8 ☐ Past Medical History (PMH)
 - ▲ include anything that would be on the Summary of Care form
 - ▲ surgeries
 - ▲ medical conditions - chronic, current
 - ▲ medications
 - ▲ drug allergies
 - ▲ head injuries
 - ▲ other serious injuries
 - ▲ caffeine
 - ▲ nicotine
- 9 ☐ Mental Status Exam (MSE)
 - ▲ cooperativeness
 - ▲ appearance (grooming, clothing)
 - ▲ speech (volume, rate, rhythm)
 - ▲ motor activity (agitated, retarded)
 - ▲ mood (how pt. says he feels)
 - ▲ affect (how pt. appears, range, congruence to thought content)
 - ▲ thought process (logical, coherent, goal-directed)
- 10 ☐ MSE (cont.)
 - ▲ thought content (evidence of psychosis)
 - ▲ insight
 - ▲ impulse control
 - ▲ social judgment
 - ▲ cognition (memory, concentration, abstracting ability)
 - ▲ intelligence
 - ▲ summarize psychological test results
- 11 ☐ Summary/Conclusion
 - ▲ summarize briefly the history
 - ▲ answer the question asked of you
 - ▲ you may include a discussion of diagnoses that you considered, but rejected
 - ▲ you may wish to give evidence to support your diagnosis
- 12 ☐ Diagnoses
 - ▲ Axis I major diagnoses
 - ▲ Axis II personality disorder
 personality traits
 - ▲ Axis III pertinent/current medical

conditions

13 Recommendations

- ▲ PQ(NPQ)/AA(NAA) for aviation duty
- ▲ fit (unfit)/suitable (unsuitable) for general military duty
- ▲ suicide risk/ homicide risk
- ▲ “the results of the evaluation were discussed with ...”
- ▲ follow-up (or none indicated)
- ▲ “call me at ___ if questions”
- ▲ other recommendations

NAVY SPECIAL PSYCHIATRIC RAPID INTERVENTION TEAM (SPRINT) AND CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

LEARNING OBJECTIVE: Understand the concept, staffing, function and utilization of Navy SPRINT teams and recommendations for the use of CISD.

I. HISTORICAL ACCOUNT

S. L. E. Marshall, a World War II historian, gathered soldiers shortly after each battle to piece together its details. Emotional relief was noticed after those group processes. In November 1975 a collision between the USS Belknap and the USS John F. Kennedy resulted in loss of life and long-term psychiatric sequelae were noticed afterwards. Disasters on the USS Guam and USS Trenton in January 1977 suggested the formation of a SPRINT team.

The first SPRINT deployment was called by the US Coast Guard in October 1978 to respond to a critical incident on the USCG cutter Cuyahoga. In February 1983 the Navy SPRINT teams were incorporated in the Navy's Mobile Medical Augmentation Readiness Teams (MMART) and were deployed following the bombing of the Marine Corps barracks in Beirut, Lebanon. In 1987, the Navy Psychiatry Specialty Advisor CDR John Mateczun had the foresight of modifying SPRINT teams from their traditional 12 members to fewer members (2-5) who could conduct Critical Incident Stress Debriefing (CISD) in a more efficient and prompt response to relatively smaller disasters. At that time CDR Nader Takla, leader of SPRINT Team two in Portsmouth, co-authored a point paper on the transition to adopt CISD team deployments with LCDR Michael Dinneen and LT Kathy Machol. Since then full SPRINT and partial CISD teams were deployed by requests from Coast Guard, Marine Corps, and Navy commands following incidents, aircraft mishaps, suicides, etc... Examples included the Marine Corps barracks bombing in Beirut, USS Stark, USS Lawrence, USS Bonefish, USS Vincennes, USS Iowa, USS Lexington, and several aviation squadrons at NAS Dallas, Yuma, and Twenty Nine Palms. Interestingly, the USS Cunningham, which was the first ship to arrive to the aid of the USS Stark and its personnel were exposed to the gory sights of the disaster, did not receive any critical incident debriefing. Several years later, many of its personnel were noticed to flock to the department of psychiatry in Portsmouth with various psychiatric and alcohol use disorders.

Training of psychiatric residents and staff was conducted to broaden the utilization of CISD. The model for debriefing was adopted from that of Jeffrey Mitchell, PhD of the University of Maryland who had been training firefighters and police department personnel to recognize and apply CISD in order to reduce burnout, attrition, and delayed post-traumatic psychiatric sequelae.

II. TEAM STRUCTURE

A full complement of a SPRINT team consists of 2 psychiatrists, 2 clinical psychologists, 1 psychiatric nurse, 1 chaplain, 1 social worker, and 4 neuropsychiatric technicians (hospital corpsmen). A partial CISD team can be tailored to the size of the incident and usually consists of 2-5 trained members. There are two NAVY SPRINT teams: West Coast SPRINT-I at the Naval hospital, San Diego (619) 532-8551 and East Coast SPRINT-II at the Naval Hospital, Portsmouth (804) 398-5281. The team leader is usually available through the respective department of psychiatry. Consulting with the team leader is beneficial to determine the size of the team and the appropriate time for the formal debriefing of survivors depending on the intensity of the disaster. The approximate ratio of 2 debriefers for the first 30 survivors and an additional debriefer for each additional 30 survivors. NAMI psychiatry may be able to provide a maximum of 1-2 debriefers for a CISD for an aviation or operational community. After contacting the debriefing team and determining the appropriate size of the team, BUMED-Code 311 can be contacted by message by the requesting command's CO to obtain approval of the debriefing event. The hosting command pays travel and per diem for the debriefers.

III. WHAT IS A CRITICAL INCIDENT

- A. Line of Duty deaths and/or serious Line of Duty injuries.
- B. Suicide or serial suicides.
- C. Any high power event (tragic death or mass casualty) with excessive media interest.
- D. Prolonged incident with resultant change in behavior, regression of personnel, persistence of symptoms after the incident ends, intensification of symptoms or presence of group symptoms, and escalation of conflict between rescue crews.

IV. OBJECTIVES OF A CRITICAL INCIDENT DEBRIEFING

- A. To provide a psychological and educational process.

- B. To accelerate normal recovery in normal people having normal reactions to an abnormal event.
- C. To identify and assist local medical and mental health resources who will provide follow-up if necessary.
- D. To assist in halting further rumors, reinforce group identity, and facilitate return to a pre-crisis level of functioning.
- E. To prevent long-term impairment such as drug/alcohol abuse, PTSD, psychiatric disorders, suicidal behavior, violent or acting out behavior, marital problems and child abuse.
- F. To reduce potential for personnel attrition, loss of personnel productivity due to hospitalization, medical boards, LIMDU, decreased work performance, etc.

V. MISCONCEPTIONS OF SPRINT FUNCTIONS

- A. Dispense tranquilizers.
- B. Tell people how to feel.
- C. Conduct group therapy.
- D. Identify personnel who should be discharged from the military.
- E. Investigate the incident and determine blame.
- F. Take control and provide leadership.

VI. CISD TEAM ASSUMPTIONS

- A. People are capable of managing grief with proper support.
- B. People are normal until proven otherwise.
- C. Focus on current problems, here and now.
- D. Be very cautious about advice.
- E. Reinforce positive activities, remind survivors of skills and strengths.
- F. Never be pushy, leave when rejected - be prepared to return when needed.
- G. Dispel myths/misconceptions regarding:
 - ◆ medications
 - ◆ telling people how to feel

- ◆ determination of blame as command's agent

VII. STAGES OF A CRISIS

- A. **Pre-crisis:** intrapsychic and interpersonal equilibrium.
- B. **Impact:** "Nothing like this has ever happened to me before".
- C. **Crisis:** Confusion/disorganization, trial and error, then reorganization.
- D. **Resolution:** regain control over emotions and work toward a solution.
- E. **Post-Crisis:** individuals either (a) integrate the experience with potential for growth (re-establish equilibrium), (b) regress (with potential for delayed reaction), or (c) develop a chronic oscillation between defensive numbness (denial) and intensive reenactment of the traumatic event (intrusive thoughts).

VIII. SEQUENCE OF CRITICAL INCIDENT REACTIONS

- A. Disbelief, confusion, and hesitation.
- B. Function on "Auto-Pilot" pattern without thinking.
- C. Regain cognitive awareness of the situation and its seriousness. Check on peer group and surroundings.
- D. After conclusion of the ordeal, there is a strong desire to spend time alone.
- E. Urge to contact family or significant others to talk about the incident.
- F. Urge to re-evaluate life priorities and values.
- G. Desire to sleep (or crash anywhere to rest).
- H. Desire to seek peer group to debrief the incident.

IX. OVERVIEW OF CRITICAL INCIDENT REACTIONS

- A. People who work around gory sights and sounds report an array of emotional/physiological stress reactions, experience a vicarious/emotional pain, not only during, but also after a critical incident.

- B. Anxiety is a common reaction to the concern that survivors might still be somewhere in the wreckage, they may not have the necessary skills or equipment to perform appropriate rescue, or be able to tolerate the horror of the event.
- C. Frustration, anger, irritability, hopelessness and dejection occur at the least indication that the situation may go out of control.
- D. Diminished performance, confusion, difficulty solving problems or making decisions, memory problems regarding procedures, and distortion in visual and auditory perceptions.
- E. People tend to suppress most of their immediate reactions for fear that they might become incapacitated at the scene if they allowed themselves to feel the full horror of the situation. This suppression will eventually lead to delayed stress responses.
- F. A great sense of guilt occurs if lives are lost, regardless of prior training, skills or dedication to the rescue process.
- G. Withdrawal from co-workers and social contacts is a common delayed response.
- H. A sense of feeling betrayed by the leadership gradually develops in regards to the management of the disaster as the incident stress builds up.
- I. Many people describe delayed flashbacks of gory visual stimuli or intrusive recurrent thoughts about the incident leaving an uneasy feeling amidst a normal routine activity. There is a need to talk or obsess about the incident even though they actively avoid discussing it.

X. PERSONALITY PROFILE OF EMERGENCY PERSONNEL

Obsessive-compulsive, driven by internal motivations, action oriented, high need for stimulation and control, high tolerance for stress and ambiguity, highly dedicated, and risk takers.

XI. FACTORS THAT DETERMINE THE DEGREE OF IMPAIRMENT DUE TO A CRITICAL INCIDENT:

- A. Suddenness, intensity, duration, age, resources, education, injury or death of close ones, and extent of personal loss or injury.

- B. It is estimated that critical incidents have no effect on 3% of the population while 4% develop the most critical stress reactions. Everyone else falls in between these two extremes.

XII. CRITICAL INCIDENT STRESS SYMPTOMS (REACTIONS)

- A. Physical: exhaustion, collapse, dizziness, pain, fatigue, palpitations, nausea, diarrhea, sweating, chills, tremors, insomnia, bruxism, frequent urination or diarrhea, menstrual disturbance, or frequent headaches.
- B. Cognitive: decreased alertness, difficulty making decisions, confusion, disorientation, poor concentration, slowed thinking, anomia, amnesia, intrusive recollections, or nightmares.
- C. Emotional: panic, anxiety, fear, apathy, guilt, crying spells, depression, anger, helplessness, hopelessness, anhedonia, identification with the victims, or wish to die.
- D. Behavioral: violence, crying, hyperactivity, irritability, restlessness, withdrawal, silence, suspiciousness, increased or decreased eating, increased alcohol, drug, and caffeine intake, startle, stuttering, avoidance, or sick humor.

XIII. ADVERSE OUTCOMES OF CRITICAL INCIDENTS

- A. Decreased enthusiasm, stagnation, frustration, apathy, physical and emotional exhaustion, and deterioration in performance.
- B. The key indicators or clinical observations of these adverse outcomes are: change in behavior, regression, poor judgement, continuation or intensification of initial symptoms, and group symptoms.

XIV. MANAGEMENT OF CRITICAL INCIDENT STRESS

- A. On-scene support services.
- B. Defusion.
- C. Demobilization.
- D. Formal Critical Incident Stress Debriefing.
- E. Follow-up services: for command, personnel and dependents.
- F. Intensive exercise and/or physical activity within 24 hours.

- G. Support for significant others and outreach activities.
- H. Life outside work: the more significant it is, the better coping ability exists.
- I. Preventive training programs/pre-incident education for commands with focus on crisis intervention services and stress reduction strategies.

XV. ON-SCENE SUPPORT SERVICES

- A. Done during the incident by senior peers (personnel with same background and work skills) who are not involved in the incident.
- B. It is an encounter with individuals (not a group process) with the goal of assisting obviously distressed personnel.
- C. Provide direct and indirect support to personnel.
- D. Stay out of the internal perimeters of the scene but observe those who are involved.
- E. Keep a low profile, do not get physically involved in the operation, approach only those with obvious signs of distress e.g. crying, shock-like state, unusual behavior...
- F. Wear an ID, dress for weather, protective gear etc....
- G. Watch for political atmosphere, get to someone at the top to advise capabilities and limitations. Frequently, check with command post: to provide input if there is a noticeable poor judgment at the scene, advise on how to obtain resources, and obtain up-to-date information on the broad picture.
- H. Never ask personnel: How do you feel? Ask content questions: What happened out there? Are you injured? You look exhausted. That must have been hell...Have you ever had anything like this happen to you before? What is the worst part about this right now? What will help you right now?
- I. Listen and reassure: reinforce positive activities, remind personnel of their skills and strengths, reassure that the feelings of abnormality and the uniqueness of their reactions are all within the normal range of reactions to abnormal situations.
- J. If the person does not wish to talk and appears capable of continuing, give breathing room and recheck later on.
- K. If the person appears to be unable to continue, pull out (through your direct or delegated authority), reassure, restore to an alternative service i.e. do not send the person

back to the scene that affected him in the first place. The purpose is to remove the individual from the gory stimuli (visual, auditory, olfactory....)

- L. Be watchful for inappropriate or out-of-character behavior or emotional response e.g. denial in the face of a clear tragedy indicates extremes of terror.
- M. Do not critique, go straight to OIC if you notice a life-threatening event.
- N. Get involved with families if applicable.

XVI. DEFUSION

- A. Defusion (De-fusion) is defined as a short, unstructured group discussions that encourage A BRIEF ACCOUNT OF THE EVENT with the goal of significantly reducing acute stress. It encourages the fragmentation of the unbidden experience in an attempt to undo guilt, fear, shock, disillusion, etc.. then restructuring the pieces from each participant into an acceptable big picture.
- B. Done anywhere from 1-3 hours following a critical incident (up to 12 hours if major incident; by 8 hours people begin to shut down or repress except when there is death).
- C. Lasts from 30-60 minutes: It is a group process provided by senior peers.
- D. Best done away from the scene. Never do group process at the scene or within visual or auditory range.
- E. Include only those crews most affected, not all personnel involved in the incident as would be the case to conduct a formal incident debriefing. If personnel are physically dirty and fatigued, conduct a demobilization.
- F. Focus on core groups i.e. do not mix crews e.g. medical personnel separate from firefighters...etc.
- G. Introduction: describe how it works, provide handouts that describe symptoms to be watched for, dietary considerations, rest, sleep, phone number to reach you if necessary, give advise on how to survive the incident, and cope or interact with spouse and children...
- H. Ensure confidentiality. No need for personnel to identify themselves.
- I. Ask them to describe facts...what happened out there?

- J. A well run defusion either eliminates the need for or facilitates subsequent formal debriefing.

XVII. DEMOBILIZATION (DECOMPRESSION/DE-ESCALATION)

- A. Indicated as a substitute for defusing for large scale events involving many people, requiring longer than average shifts and multiple resources.
- B. Set up a Demobilization Center at a large facility (hanger) where personnel stop for food or drinks on their way to berthing areas at the end of their shifts.
- C. Set up small circles and small groups. Follow the same protocol for each group.
- D. Provide a 10-minute presentation: give out information on a handout regarding what to expect, what to do. Educate them about symptoms of stress, give advice and suggestions about eating, drinking, talking to their family members, to the press... Do not take information, do not deliver bad news... This is a transition from the awful to the routine.
- E. If they want to talk, give them a maximum 30 minutes, then dismiss. If there are repeated requests to talk, consider a formal incident debriefing.
- F. Feed them, but avoid sugar, coffee, fat, complex carbohydrates; give fruits, juices and sandwiches. Provide a 20-minute rest, then back to routine work (not to the scene) or to their berthing areas to sleep.
- G. Can be provided by senior peer or Chaplain.

XVIII. CRITICAL INCIDENT STRESS DEBRIEFING

- A. CISD is defined as a psychological and educational process that mitigates the impact of a horrible event, and accelerates normal recovery in normal people with normal reactions to an abnormal event.
- B. Ideal time is 24 hours after the incident up to the memorial services which usually occurs within a week. Some experts suggest that it can be harmful if conducted after 16 weeks.
- C. Conducted by trained individuals who must have comprehensive knowledge of stress reactions and CISD techniques.
- D. Never answer a question with a question, never say u'hum. Stay within the perimeters of educating and preventing.

- E. Advise the command to get the word immediately to dependents before the media gets to them.
- F. If there is an investigation, try to perform the debriefing after the investigation is completed if still within the ideal time frame. If there is a prolonged investigation, try to keep the debriefing distinctly separate from the investigation.
- G. Keep the debriefing from becoming an operational critique. If a mistake during the incident is identified, **FOCUS ON THE INTENT NOT THE CONTENT. AVOID BEING JUDGMENTAL.**
- H. Group dynamics never allow one person to take 100% of the blame or 100% of the credit. This is a group process i.e. participation by everyone will be helpful to everyone else present.
- I. Never mix family members with personnel and have a special debriefing for significant others. Never include a relative of a fatality i.e. brother, sister, wife or children of a crew that died during the event.
- J. Include only those who were involved in the event, but do not forget those who provided support services e.g. air traffic controllers, dispatchers, medical personnel, clean up crew etc....
- K. Personnel attending the debriefing must be relieved of duty during the process: no interruptions, no breaks, no phone calls, quiet non-verbal bathroom calls.... (Once a momentum is built up, it tends to be totally disrupted if a break is taken.)
- L. No notes, no audio or video recordings and no media personnel.
- M. **STRICT CONFIDENTIALITY MUST BE MAINTAINED AND ASSURED. NOTHING LEAVES THE ROOM.**
- N. If the group is larger than 30 individuals, split into core groups depending on their proximity or level of involvement with the gory scene or events.
- O. If someone begins to cry, acknowledge, validate, reassure and move on to the next individual.
- P. The CISD must be led by someone who has knowledge in mental health in order to recognize psychopathology: depression, suicidal risks, anxiety, psychosis... Individuals with psychopathology should be excluded from the debriefing and referred to the nearest mental health facility.

- Q. In addition to the leader, a co-leader (Chaplain, Flight Surgeon, or other medical staff) and/or one or two peers can assist, preferably with experience in regards to the mission of the unit that was subjected to the disaster, e.g. pilot, chief, air crew etc.... This is a peer driven but mental health professional guided group process.
- R. Leader, co-leader and peers should be evenly distributed around the room in an oval or circular configuration interspersing among the participants.
- S. One of the peers (a senior) should be seated next to the door, in case someone suddenly walks out, then (s)he would go after him/her for assessment, assurance and safe return to the debriefing.
- T. Each participant speaks only for him/herself, about his/her own reactions.

XIX. TECHNIQUE FOR CRITICAL INCIDENT DEBRIEFING

- A. **INTRODUCTORY REMARKS:** refer to previous paragraph regarding the definition and general guidelines.
- B. **FACT PHASE:**
 - * Who are you?
 - * What was your particular role (job) during the event?
 - * What happened out there as you saw it?
- C. **THOUGHT PHASE:**
 - * Once you got off auto-pilot...what thoughts jumped or stuck in your mind?
 - * Bring the facts out there to the thoughts up here (pointing to one's head).
- D. **REACTION PHASE:**
 - * Can you tell me what was the worst part about this event?
 - * What part hurt you the most?
 - * What part got under your skin?
 - * Suppose you can go back to that event, what part would you erase or change?
- E. **SYMPTOM PHASE:**
 - * What symptoms did you experience, at the scene, after leaving the scene, when you went home to your family, a few days later...?
- F. **TEACHING PHASE:**

- * Model the teaching according to what they say in the Symptom Phase: Did anybody have this or that? Or some people have this or that...and that's normal. Some people do not have any symptoms and that's okay too...
- * Let me tell you more: teach about the case, i.e. suicide education if this is a suicidal case, grief education if there is accidental death, etc....
- * Talk about practical things: eating, drinking, what to say to the children, spouses etc....
- * Is there anything about this event that is "vaguely positive"?

G. REENTRY PHASE:

- * They can ask any question.
- * They can bring in any new material.
- * Listen for what was unsaid, give them permission to experience a horrible thought or feeling.
- * Inform them about how they can reach you.

APPENDIX O

SECNAVINST 6320.24A
18 FEB 1999

SAMPLE LETTER

COMMANDING OFFICER REQUEST FOR ROUTINE (NONEMERGENCY) MENTAL HEALTH EVALUATION

FOR OFFICIAL USE ONLY

6320
Ser
Date

From: Commanding Officer, (Name of Command)
To: Commanding Officer, (Name of medical treatment facility
or clinic)
Subj: COMMAND REFERRAL FOR MENTAL HEALTH EVALUATION OF (SERVICE
MEMBER RANK, NAME, BRANCH OF SERVICE AND SSN)
Ref: (a) DoD Directive 6490.1, "Mental Health Evaluations of
Members of the Armed Forces," 1 Oct 97 (NOTAL)
(b) SECNAV Instruction 6320.24A, "Mental Health
Evaluations of Members of the Armed Forces,"
(c) Section 546 of Public Law 102-484, "National Defense
Authorization Act for Fiscal Year 1993," Oct 1992
(d) DoD Directive 7050.6, "Military Whistleblower
Protection," 12 Aug 95 (NOTAL)
Encl: (1) My ltr (SSIC, serial #, date)

1. Per references (a) through (d), I hereby request a formal mental health evaluation of (rank and name of service member).
2. (Name and rank of service member) has (years) and (months) active duty Service and has been assigned to my command since (date). Armed Services Vocational Aptitude Battery scores upon enlistment were: (list scores). Past average performance marks have ranged from _____ to _____ (give numerical scores). Legal action is/is not currently pending against the service member. (If charges are pending, list dates and UCMJ articles). Past legal actions include: (List dates, charges, nonjudicial punishments and/or findings of Courts Martial.)

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16 FEB 1998

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Subj: COMMAND REFERRAL FOR MENTAL HEALTH EVALUATION OF (SERVICE MEMBER RANK, NAME, BRANCH OF SERVICE AND SSN)

3. I have forwarded to the service member a letter that advises (rank and name of service member) of his (or her) rights. This letter also states the reasons for this referral, the name of the mental health care provider(s) with whom I consulted, and the names and telephone numbers of judge advocates, DoD attorneys and/or Inspectors General who may advise and assist him (or her). A copy of this letter, enclosure (1), is attached for your review.

4. Should you wish additional information, you may contact (name and rank of the designated point of contact) at (telephone number).

5. Please provide a summary of your findings and recommendations to me as soon as they are available.

(Signature)

Name of commanding officer

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18 FEB 1999

SAMPLE LETTER

SERVICEMEMBER NOTIFICATION OF COMMANDING OFFICER
REFERRAL FOR MENTAL HEALTH EVALUATION

FOR OFFICIAL USE ONLY

6320

Ser

Date

From: Commanding Officer, (Name of Command)
To: Commanding Officer, (Service member's rank, name and SSN)
Subj: NOTIFICATION OF COMMANDING OFFICER REFERRAL FOR MENTAL
HEALTH EVALUATION (NON-EMERGENCY)
Ref: (a) DoD Directive 6490.1, "Mental Health Evaluations of
Members of the Armed Forces," 1 Oct 97 (NOTAL)
(b) SECNAV Instruction 6320.24A, "Requirements for Mental
Health Evaluations of Members of the Armed Forces"
(c) Section 546 of Public Law 102-484, "National Defense
Authorization Act for Fiscal Year 1993," Oct 1992
(d) DoD Directive 7050.6, "Military Whistleblower
Protection," 12 Aug 95

1. Per references (a) through (d), this letter is to inform you I am referring you for a mental health evaluation.
2. The following is a description of your behaviors and/or verbal expressions I considered in determining the need for a mental health evaluation: (Provide dates and a brief factual description of the service member's actions of concern.)
3. Before making this referral, I consulted with the following mental health care provider(s) about your recent actions: (list rank, name, corps, branch of each provider consulted) at (name of medical treatment facility (MTF) or clinic) on (date(s)). (Rank(s) and name(s) of mental health care provider(s)) concur(s) this evaluation is warranted and is appropriate.

OR

Consultation with a mental health care provider prior to this referral is (was) not possible because (give reason; e.g., geographic isolation from available mental health care provider, etc.)

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4. Per references (a) and (b), you are entitled to the rights listed below:

a. The right, upon your request, to speak with an attorney who is a member of the Armed Forces or is employed by the Department of Defense who is available for the purpose of advising you of the ways in which you may seek redress should you question this referral.

b. The right to submit to the DON Inspector General or to the Department of Defense Inspector General (DoD IG) for investigation, an allegation that your mental health evaluation referral was in reprisal for making or attempting to make a lawful communication to: a Member of Congress; any appropriate authority in your chain of command; an IG; or a member of a DoD audit, inspection, investigation or law enforcement organization.

c. The right to obtain a second medical opinion and be evaluated by a mental health care provider of your own choosing, at your own expense, if reasonably available. Such an evaluation by an independent mental health care provider shall be conducted within a reasonable period of time, usually within 10 business days, and shall not delay nor substitute for an evaluation performed by a DoD mental health care provider.

d. The right to communicate, without restriction, with an IG, attorney, Member of Congress, or others about your referral for a mental health evaluation. This provision does not apply to a communication that is unlawful.

e. The right, except in emergencies, to have at least 2 business days before the scheduled mental health evaluation to meet with an attorney, IG, chaplain, or other appropriate party. If I believe your situation constitutes an emergency or your condition appears potentially harmful to your well-being and I judge it is not in your best interest to delay your mental health evaluation for 2 business days, I shall state my reasons in writing as part of the request for the mental health evaluation.

f. If you are assigned to a naval vessel, deployed or otherwise geographically isolated because of circumstances

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related to military duties that make compliance with any of the procedures in paragraphs 3 and 4, impractical, I shall prepare and give to you a copy of the letter setting forth the reasons for my inability to comply with these procedures.

5. You are scheduled to meet with (name and rank of the mental health care provider) at (name of MTF or clinic) on (date) at (time).

6. The following authorities can assist you if you wish to question this referral:

a. Military Attorney: (Provide location, telephone number and available hours of nearest Naval Legal Service Office.)

b. Inspector General: (Provide rank/title, name, address, telephone number and available hours for service and DoD IG. The DoD IG number is 1-800-424-9098.)

c. Other available resources: (Provide rank, name corps/title of chaplains or other resources available to counsel and assist the service member.)

(Signature)

Name of commanding officer

I have read the letter above and have been provided a copy.

Service member's signature: _____

Date: _____

OR

The service member declined to sign this letter which includes the service member's Statement of Rights because (give reason and/or quote service member).

Witness's signature: _____

Date: _____

Witness's printed/typed rank and name: _____

(Provide a copy of this letter to the service member.)

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PSYCHIATRIC EMERGENCIES

LEARNING OBJECTIVE: Describe the management of psychiatric emergencies and understand the techniques involved in verbal, physical and chemical restraint.

I. INTRODUCTION

- A. Psychiatric emergencies require time and patience. Knowledge of medical illnesses that lead to acute psychiatric symptoms, as well as knowledge of how to handle violent or agitated patients, is necessary.
- B. Thorough medical history and physical examination must be performed on all patients in acute distress even if manifesting psychiatric symptoms.
- C. The clinician must entertain the possibility of multiple diagnoses, i.e. psychiatric patients can have medical conditions too.
- D. Assessment should include risk of harm to self or others.

II. CLINICAL PRESENTATIONS OF PSYCHIATRIC EMERGENCIES

- A. **SUBDUED BEHAVIOR** (Psychomotor Retardation) can be caused by the following conditions:
 - 1. Mood Disorders.
 - 2. Substance-Related Intoxication (CNS depressants).
 - 3. Metabolic Disturbance.
 - 4. Dementia or Delirium.
 - 5. Schizophrenia (catatonic type), Schizoaffective Disorder.
 - 6. Suicidal behavior.
 - 7. Bereavement.
- B. **BIZARRE BEHAVIOR** (Impaired Reality Testing) can be caused by the following conditions:
 - 1. Mental Disorders due to a General Medical Condition or Substance-Related Disorders.
 - 2. Schizophrenia (disorganized or undifferentiated), Schizoaffective Disorder.
 - 3. Bipolar I Disorder.
 - 4. Brief Psychotic Disorder or Schizotypal Personality Disorder.
 - 5. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (Pervasive Developmental, Autistic, or Mental Retardation conditions).
 - 6. Religious or cultural beliefs or experiences.

- C. **ASSAULTIVE OR AGITATED BEHAVIOR** (Psychomotor Agitation) can be caused by the following conditions:
1. Psychotic Disorders.
 2. Mental Disorders due to a general Medical Condition (such as Head Trauma) or Substance-Related Disorders (Intoxication, CNS stimulants).
 3. Personality Disorders (Antisocial, Borderline, Paranoid).
 4. Schizophrenia or Schizophreniform Disorder.
 5. Bipolar Disorder.

III. POTENTIAL LIFE-THREATENING MEDICAL CONDITIONS WHICH MAY BE MANIFESTED BY PSYCHIATRIC SYMPTOMS

- A. **Meningitis, Encephalitis:** Search for fever, tachycardia, leucocytosis, meningeal signs, and headaches.
- B. **Hypoglycemia:** Search for a history of diabetes, weakness, sympathetic hyperactivity, and low blood glucose.
- C. **Hypertensive Encephalopathy:** Search for a history of hypertension and high blood pressure on examination.
- D. **Intracranial Hemorrhage:** Search for headaches, meningeal or focal signs.
- E. **Diminished Cerebral Oxygen:** Search for signs of cardiac or pulmonary insufficiency, and severe anemia.
- F. **Poisoning:** Search for access or exposure to tricyclic antidepressants, organophosphates, opiates, and barbiturates.
- G. **Wernicke-Korsakoff:** Search for a history of alcohol dependence, malnutrition, disorientation, confusion, impaired memory, confabulation, apathy, lethargy, frightening (visual) hallucinations, peripheral neuropathy, ataxia, and ophthalmoplegia.
- H. **Delirium Tremens:** Search for a history of recent alcohol abstinence, irritability, tremulousness, hyperactivity, insomnia, fever, seizures, and visual hallucinations.

IV. NON LIFE-THREATENING CONDITIONS WHICH MAY BE MANIFESTED BY PSYCHIATRIC SYMPTOMS

- A. **Functional Psychosis:** Search for a history of Schizophrenia, Mood (Bipolar) disorders, Brief Psychotic Disorder, Psychotic Disorder (Atypical Psychosis), Delusional Disorder, Borderline Personality Disorder, or Anorexia Nervosa (loss of 25% body weight or more).
- B. **Toxic:** Search for Substance Related Disorders (Alcohol, Amphetamines, Cocaine, Hallucinogens, Inhalants, Opiates), or

use of Anticholinergics, Organophosphates, Heavy Metals, Carbon Monoxide, Carbon Disulfide, Wilson's Disease, or industrial agents used in shipyards.

- C. **Neoplastic:** Search for primary tumors, metastases of breast or lung tumor, carcinomatosis, or pheochromocytoma.
- D. **Vascular:** Search for intracranial hemorrhage, aneurysms, or subdural hemorrhage.
- E. **Medication Toxicity:** Search for the recent use of Antabuse, Lithium, Antipsychotics, Antidepressants, Antituberculosis (INH, cycloserine), Anti-Inflammatory (Cortico-Steroids, Indomethacin, Phenylbutazone), Antihypertensive (Reserpine, Methyl Dopa), or Cardiac (Digitalis, Procainamide, Propranolol) agents, Cimetidine, Bromide, or Idiosyncratic and Synergistic effects of drugs.
- F. **Metabolic, Endocrine, or Nutritional:** Search for recent fluid and electrolyte imbalance (Ca, Mg, phosphates, glucose), heat-stroke, cold exposure, porphyria, adult PKU, organ dysfunction (thyroid, parathyroid, pituitary), respiratory, cardiac, or liver failure.

V. HOMICIDAL BEHAVIOR

- A. Factors which increase the likelihood of an assault include agitation, psychosis (especially paranoid delusions and command hallucinations), previous violence, recent stressors, intoxication with drugs or alcohol, withdrawal from alcohol or sedative-hypnotics, and organic disorders.
- B. Some threats of assault (typically from borderline, antisocial, or histrionic personality disorder patients) are manipulative and without true intent. Although these evaluations can be difficult, **always err on the side of caution.** Assume, at least initially, that all threats are potentially genuine. Threatening manipulative patients, on perceiving that they are not being taken seriously, may commit violent acts simply to prove that the clinician should have believed them.
- C. Homicidal behavior in the military frequently revolves around an interpersonal relationship where rejection, deceit, or severe humiliation were experienced by the patient.
- D. Prediction of homicidal behavior is like the weather forecast (only good for 24 - 48 hours).

E. EVALUATION:

1. Is a psychiatric illness responsible for the patient's threatening behavior? How specific are the patient's plans for violence? Does the patient have a specific intended victim? Has the patient obtained the means (weapon)? Does the patient have a specific reason for committing the violent act (revenge against a Commanding Officer for a poor evaluation, domestic dispute, etc.)?
2. Has the patient committed violent acts in the past?
3. Has the patient been using drugs or alcohol?
4. Does the patient have a criminal record, and what are the specifics?

F. DUTY TO WARN AND PROTECT: The physician has a duty to warn and protect the intended victim. If a patient is directly threatening to kill a specific person, the physician must notify the potential victim (Duty to Warn), the patient's Commanding Officer, the local police or the family or friends of the intended victim who are likely to be able to intervene. In addition, the physician must do anything reasonable to protect the intended victim, such as hospitalize the patient (Duty to Protect). The duty to warn and to protect take priority over the patient's confidentiality.

G. Hospitalization, medication and restraint may be needed.

H. If psychiatric disorders are ruled out, recommend that the command obtain a pre-trial confinement. The brig is often the safest place for dangerous individuals.

VI. MANAGING PSYCHIATRIC EMERGENCIES

When it becomes apparent that an individual represents a possible risk to harm self or others, it is necessary for the physician to consider initiating restraint procedures.

- A. Safe setting:** When a patient has been identified as a possible threat to harm self or others, it is imperative that the (s)he be placed in an environment that is free of equipment that might aid in carrying out this threatening behavior (surgical instruments, etc.)
- B.** Allow adequate time to assess the patient.
- C.** Protect the dignity of the patient. Be aware of the stereotypes and attitudes about psychiatric patients. Recognize your countertransference and that of your staff towards mentally ill patients.

- D. Provide privacy. Avoid interviewing psychiatric patients within earshot of others if possible.
- E. Acknowledge the patient's concerns, even if they are unrealistic or delusional. Observe the patient's behavior, speech, content, timing, posture, eye contact, etc. in response to your communication.
- F. Provide a firm, empathetic and honest approach.
- G. Obtain a reliable history, which may include obtaining information from the command, significant others and friends of the patient.
- H. Rule out organic etiologies for the presenting illness with appropriate physical exam and labs (BAL, Drug screen, etc.).
- I. Avoid dangerous assumptions by being aware that:
 - 1. Absence of cognitive impairment does not automatically rule out brain dysfunction.
 - 2. Psychosocial stressors may not be the only etiology of the acute distress.
 - 3. Recurrent symptoms may not always mean a recurrent cause.
 - 4. Descriptive labels (depressed, psychotic) may not always be equated with the same causal explanation or may not always have the same etiology.
 - 5. Other consultants may not always be as thorough and comprehensive as you are - trust your own judgment - leave no stone unturned.
- J. Clues to an organic etiology:
 - 1. Patient is over forty, no previous psychiatric history.
 - 2. Significant impairment of orientation, memory, coherence, or visual or tactile hallucinations.
 - 3. Abnormal vital signs especially fever or tachycardia
 - 4. Signs of Autonomic Nervous System dysfunction.
 - 5. Sudden onset of psychosis with no clear precipitating event.

VII. MANAGEMENT OF THE VIOLENT PATIENT

- A. Key Interventions:
 - 1. Rapid Assessment of the Level of Violence
 - 2. Physical Restraints
 - 3. Chemical Restraints
 - 4. Secondary survey as soon as it can be performed safely
 - 5. Appropriate diagnostic and supportive interventions
 - 6. Reassessment
 - 7. Disposition
 - 8. Medico-legal concerns

- B. Definition of Violence:** Forceful act or threat; the intent of which is to injure, damage, maim or destroy a person or object.
- C. Violence Statistics:** Murders have doubled in past 20 years.
1. Contributors:
 - a. Psychostimulants
 - b. Easy availability of handguns
 - c. Gangs
- D. Three Hypothetical Levels of Violence**
1. **Level One:** Patient aroused and trying to reach out to physician verbally:
 - a. **Nonverbal signs:** Autonomic signs of fight-flight; tension in various muscle groups; restless or nervous movements; startle response easily evoked.
 - b. **Verbal Signs:** Although angry, patient responds to therapeutic interventions.
 - c. **Management Techniques:**
 1. **General Environment:** Minimize waiting time for the agitated patient. Presence of uniformed staff; Area clean of any dangerous objects; interview room not secluded; equal access to door for both patient and physician.
 2. **Body Language:** Enter room slowly. Stay at least 8 feet from patient. Approach on the left side of patient (90% are right-handed) and use a balanced stance. Avoid the "Animal Challenge Position": eye-to-eye; shoulder-to-shoulder; face-to-face.
 3. **Verbal Approach:** Speak politely in a caring, but firm manner. Talk about what seems emotionally relevant to patient rather than questioning according to a standardized format. Restate patient's fears and complaints in the form of a problem to be solved together with the physician acting as patient's ally to combat the frightening feelings. Allow patient to reassure physician concerning possibility of violence.
 4. **Example of Cascade of Questioning:**
 - a. "Hello, I'm Dr. --. How can I help you?"
 - b. "You appear angry. Let's talk about it."
 - c. "Do you feel like you are going to lose control?"
 - d. "Do you have a weapon?"
 - e. "Do you want some medication to help calm you?"

2. **Level Two:** Patient agitated and testing situational limits. Further verbal intervention contraindicated. Patient's behavior demands that physician set limits.
 - a. **Verbal Signs:** Protesting, refusing, and challenging physician's interventions.
 - b. **Nonverbal Signs:** Exaggeration of Level One autonomic features. Pacing in menacing fashion; Sudden random movements; Hands in fists; Arms raised; Teeth clenched or bared; Often unblinking, wide-eyed stare.
 - c. **Management Techniques:** General environmental measures and body language are the same as for Level One. Establish appropriate limits for patient's behavior. Avoid pleading, bargaining, threatening, and false reassurance. Maintain focus on patient's impending loss of control. Call for help from corpsmen, restraint team, or security guards.
3. **Level Three:** Actual Violent Attack.
 - a. **Adaptive Responses:** Blocking punches; escaping from patient; getting help.
 - b. **Mistakes:** Freezing in panic; blocking patient's exit; failing to defend oneself; using excessive force in subduing patient; subsequently acting out in revenge.

VIII. RESTRAINTS

- A. There are three types of restraint: verbal, physical and chemical.
- B. Restraint teams should be organized prior to the emergency.
- C. The restraint team consists of;
 1. The team leader (which will usually be the doctor)
 2. Four other members who are responsible for securing each of the patients' limbs.
- D. When it is apparent that a patient is "out of control" and may need restraint, the team is called as a "show of force".
- E. The team leader should place him/herself in front of the patient at a distance of approximately 5 feet with other team members to each side. Verbal restraint measures are then initiated. Reassure the patient that they are safe and that you want to help them. Offer them a quiet area to calm down. Never try to out yell the patient. You may successfully calm the patient by speaking very softly, therefore requiring the

patient to lower their voice in order to understand what you are saying to them.

- F. Offer the patient medication to help calm them as chemical restraint is usually more effective than physical restraint. When it is apparent that verbal restraint measures are going to be unsuccessful and the patient refuses medication, it will then be the responsibility of the team leader to initiate physical restraint.
- G. If PCP intoxication is suspected, avoid physical restraints if at all possible.
- H. **FIVE POINT RESTRAINT TECHNIQUE:**
 1. The procedure has to be pre-rehearsed by the team members. Team members have to be pre-designated in order to be summoned on a short notice.
 2. Once initiated, it should proceed without hesitation.
 3. Full leather restraints are the most effective.
 4. Spread-Eagle Position: Each team member is assigned to take on one extremity and one team member to hold the head (usually performed by the team leader).
 5. Approach the patient simultaneously at the command of the team leader.
 6. Grasp each specified extremity at the major joint to avoid fracture.
 7. Apply the full leather restraints to the distal joints (wrists and ankles) and secure to the bed which must be heavy enough not to tip over with the patient in it (a gurney is not a good choice).
 8. Continually explain or talk to the patient about your intentions and reasons.
 9. Remain aware of your own body parts.
 10. Once restrained, assign one or two persons to monitor and interact with the patient to ensure familiarity and reduce threat.
 11. Monitor and document vital signs, coherence, orientation, alertness, etc each 10-15 minutes.
 12. Reduce stimulations, noises, sudden moves, strangers, and keep patient informed of what you plan to do.
 13. Document the necessity for the takedown, names of the team members involved, exact procedure, and any complications. Specify time in restraints.
 14. Do not forget to write the order to use restraints, specifying leather restraints which are the most effective.
 15. Once the patient verbalizes ability to control behavior and the staff members concur, (s)he may be allowed to demonstrate that ability by releasing one restraint at a time to regain the confidence of the patient and the staff.

16. Finally, if the patient's agitation continues to escalate after restraining, conduct a medical evaluation (with a chaperon) to prepare for using medications.

IX. CHEMICAL RESTRAINTS (PSYCHOTROPIC MEDICATIONS)

- A. If the patient has just been restrained, hold the medications to see if (s)he will de-escalate first.
- B. Use psychotropics only if further assessment cannot proceed without tranquilization. Usually, either benzodiazepines or antipsychotics are used.
- C. First, check the patient's vital signs if possible. Low-potency antipsychotics (chlorpromazine) should be avoided if the patient is hypotensive. If fever is present, avoid antipsychotics since they cause poikilothermia and can interfere with a fever workup.
- D. If intoxication or withdrawal from alcohol or sedative-hypnotics is suspected, benzodiazepines are the drugs of choice, since antipsychotics may precipitate withdrawal seizures. If stimulant intoxication is suspected, benzodiazepines are indicated.
- E. DRUG CHOICE:
 1. **Benzodiazepines:** Lorazepam (Ativan), 1-2 mg orally or IM, is the usual choice, and may be repeated hourly as needed unless signs of toxicity (ataxia, dysarthria, nystagmus) are present. Benzodiazepines may cause disinhibition, which may be difficult to differentiate from worsening agitation. If disinhibition or toxicity occurs, start an antipsychotic.
 2. **Antipsychotics:** The drug of choice for immediate tranquilization is Haloperidol (Haldol) or Droperidol. Droperidol, which is most often used for induction of anesthesia, offers several potential advantages over haloperidol including a more rapid onset of action when given intramuscularly (IM) and a shorter half-life. Chlorpromazine (Thorazine) is the next choice. Initially, offer oral concentrate Haloperidol (or Chlorpromazine) if available. Use IM Haloperidol or Droperidol if oral concentrate is refused.

DOSAGES:

HALOPERIDOL:

- a. Administer periodic small doses (instead of one large dose) to titrate the patient to a level of behavioral control and still allow him/her to be alert for further evaluation.

- b. 2.5 mg-5 mg IM or PO every 30 minutes until calm.
- c. Maximum dose: 60 mg / 24 hours.

DROPERIDOL:

- a. 5 mg IM or IV. Repeat in 30 minutes if needed.

CHLORPROMAZINE:

- a. 100 mg PO or 50 mg IM / hour until calm.
- b. Maximum dose: 800 mg / 24 hours.

- 3. **Combined Antipsychotic-benzodiazepine:** A combination of the two drugs is safe and is often used. Typically, the combination is haloperidol (Haldol) 5 mg and lorazepam (Ativan) 2mg given together IM. These combinations are safe and may be more effective than either drug alone, although that has not been conclusively proved.

X. SPECIAL CLINICAL SCENARIOS

- A. **Personality Disorders:** Patients with these disorders may present as an emergency due to their behavior (self-harm or suicide attempts, escalating anger or violence, homicidal threats). The behaviors are frequently combined with alcohol or substance intoxication. The initial work-up should be the same as for any patient with similar symptoms. Don't overlook other pathology by labeling the patient. Past history of same behavior may be available helping to confirm the diagnosis. These patients respond to firm and consistent verbal warnings and limit-setting.
- B. **LSD Intoxication:** The patient is usually panicky or frightened, but not disruptive. Provide reassurance and a quiet dimly lit safe place. Low doses of Haldol can be administered if psychotic symptoms are present, and Ativan can be administered for anxiety symptoms. The patient should be placed on "No Duty" until complete recovery from the LSD trip can be observed.
- C. **PCP Intoxication:** The patient presents with disorganized or bizarre behavior. Sometimes severe agitation and unprovoked violence are encountered. Obtain adequate personnel before initiating a takedown and attempt to avoid physical restraints if possible. Utilize rapid tranquilization with Ativan and Haldol. The physician must monitor the patient's level of consciousness, blood pressure, temperature, and muscle activity and must be ready to treat severe medical abnormalities as necessary. Close observation is necessary even after the patient has initially calmed down.
- D. **Amphetamine Intoxication:** Often seen with paranoid delusions, agitation, visual and tactile hallucinations, and usually difficult to differentiate from cocaine intoxication. Admit the patient to inpatient unit, observe, and administer Haldol for agitation.

REFERENCES AND READING LIST

The reference books, articles, novels, and video tapes listed here may be consulted to gain in-depth knowledge in General Psychiatry as well as Aviation and Operational/Military Psychiatry. Most of these references are available at NAMI Psychiatry Department's library.

I. GENERAL PSYCHIATRY

1. Diagnostic and Statistical Manual: Fourth Edition (DSM-IV) 1994
2. Comprehensive Textbook of Psychiatry: Kaplan and Sadok
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20. Occupations, Occupational Chemical Exposures and Psychiatric Disorders: Dembert M
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61. Emergency Psychiatry at the Crossroads: Lipton, Goldfinger. Jasey-Bass, 1986
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