

# **QUICK OPERATIONAL MENTAL HEALTH**

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# BACKGROUND

- A.B., M.D., Georgetown University
- First 3-year GMO since WWII - Forrestal
- First Dept Head tour - Okinawa
- Emergency attending Portsmouth 5 years
- First MAP mobilization: to Kearsarge in support of joint operations in Kosovo
- Now: directly reporting to Commander, NMCSO, for operational medicine issues

# OBJECTIVES

- Identify common mental health problems
- Discuss the common problems
- Impart practical advice on management
- Review administrative issues
- Identify three steps you must take prior to deployment

# COMMON PROBLEMS

- Suicidal thoughts
- Suicidal behavior
- Depression
- Grief
- Psychosis
- Posttraumatic stress

# SUICIDE

- Suicide gesture vs attempt
- Suicidal thoughts vs behavior
- Suicide continuum
  - wondering, thinking, planning, resolve, action
- Common ways to commit suicide
  - pills, cutting, jumping, CO, hanging, GSW
- Quick demographics of suicidal behavior

# DEPRESSION

- More than depressed mood
- Diagnosis requires symptoms, classically:
  - loss of interest, loss of sleep, loss of energy, loss of weight or appetite, loss of activity, loss of concentration, guilty thoughts, thoughts of suicide
- Symptoms present for at least two weeks
- Under diagnosed and under treated when diagnosed

# GRIEF

- Emotional distress at the loss of a loved one is not pathological; it is normal
- Loss is personal, you have to see it from their eyes
- Death of a parent is very hard
- Loss includes more than death, it includes relationships
- Marital rejection can be seen as grief

# PSYCHOSIS

- Two major illness: Bipolar Disorder and Schizophrenia
- To distinguish, look at sleep
- Symptoms: hallucinations, paranoia, bizarre thoughts, unusual emotional expression, behavior that crosses the line
- Bipolars can be aggressive
- Command hallucinations

# POSTTRAUMATIC STRESS

- Exposure to life-threatening trauma: combat, disaster, rape, assault, injury
- Symptoms: re-experiencing the trauma, life events trigger the trauma, and autonomic hyperarousal
- May include aggression and seclusion
- May induce shame
- Past trauma predisposes PTSD

# SUICIDE

- Respond to thoughts, take all behavior seriously
- Being suicidal is temporary
- People kill themselves when they are alone
- Create a safe place in public
- Address issues that caused the suicidal thoughts/behavior

# DEPRESSION

- Establish a diagnosis
- Treat with SSRI, fluoxetine or sertraline
- Avoid treatment pitfalls
  - Get the right dose
  - Give the med time to work
- Consider medevac if:
  - meds do not help
  - the case is severe

# GRIEF

- Grief as a result of death falls in the Chaplain's camp
- Relationship loss will present to medical
- Usually presents as incapacitation
- Do not confuse with depression
- Depression meds not usually indicated
- They need to develop a plan and execute the plan

# PSYCHOSIS

- Document, document, document
- Sedation with a benzodiazepine
- Treatment with an antipsychotic
- Understand early side-effects of older anti-  
psychotics: dystonia
- Make plans to medevac
- Choose the right escort

# POSTTRAUMATIC STRESS

- Because of shame and guilt, they hesitate to come forward
- Avoid making this a medical or mental problem; take a sick call approach
- “I treat nightmares”
- Understand that some people do okay by using denial
- Get the rest professional help

# ADMIN ISSUES

- Members can be separated for:
  - Personality Disorder MILPERSMAN 1910-122
  - Medical Condition, Not a Disability 1910-120
- When you think psych medevac, think medical attendant: get the right attendant
- Look closely at plans given to you by other authorities and make sure they meet medical and command needs

# PRIOR TO DEPLOYMENT

- Liaison with your local mental health department to determine their preferences and business practices
- Schedule restraint training
- Learn where mental health services are located along your deployment route