Announcer (00:00)
The following is an encore presentation of conversations on healthcare.

Mark Masselli (00:08)
The veteran suicide rate is currently 1.5 times the rate of the general population. And the United States Department of Veterans Affairs says its top clinical priority is preventing suicide among all those who have served.

Dr. Craig Bryan (00:24)
Now, years later, I would say the military and veteran community are absolutely on the leading edge of this. Now, the veteran community, I have found to be way more open to this issue. and I think it's because so many of us have lost friends and loved ones, and we're sick and tired, and we know that it's a gun related issue, and we know what gun safety is.

Margaret Flinter (00:48)
Clinical psychologist, Dr. Craig Bryan is an Iraq War veteran and the author of "Rethinking Suicide: Why Prevention Fails, How We Can Do Better." His research is revealing new insights about what's leading to suicide and the role that firearm safety can play in preventing more deaths.

Dr. Bryan (01:07)
More than half who die by suicide, do not have a known mental health condition or mental illness. Is, actually something that is known about suicide as a whole. The same is true amongst civilians. And so in that sense, there's a similarity amongst veterans and non-veterans in terms of risk factors. And what this means is that I think a lot of our historic approaches to how we understand to we could best prevent suicide, at least in the United States, is really focused on mental health treatment, mental health screening, things like that. And I think what, what the statistics there would suggest is that that might be useful for helping out some veterans, but not many others.

Margaret (01:46)
This is Conversations on Healthcare.

Mark (01:58)
Welcome, Dr. Craig Bryan, to Conversations on Healthcare.

Dr. Bryan (02:03)
Oh, thanks so much for having me.

Mark (02:04)
Yeah. And you know, before we dive into your research, let's start with an overview of, of veterans are 72% higher, risk of suicide than those who haven't served. This is a reversal from earlier trend. For instance, prior to 2001, veteran suicide rates were far lower than those in the general population when comparing age groups. Suicide is also the second leading cause of death among veterans under 45. And finally, the female suicide rate for female veterans is 166% higher when compared to their civilian counterparts. I'm wondering, what do we know about the story behind these statistics, and why are we seeing such suicide increases right now?

Dr. Bryan (02:51)
Yeah, yeah. We, we think that all of these trends are related to a multitude of factors. There's, you know, one, not one single contributing cause. but we know, for instance, that some of these, contributors are that, the veteran population as a whole is aging. We know that the majority of veteran suicides, as in the, the highest number of deaths occur amongst veterans above the age of 55, who are now typically more of like Korean War and Vietnam War era. that maps onto a little bit what we know amongst us, suicide rates as a whole, the highest rates are amongst older, adults. And so we think that it's a combination of an aging veteran population, at least for those who served, you know, several decades ago. and on top of that, you're going to have, a lot of health-related issues, higher rates of disability, higher relate, higher rates of psychological conditions, and all of these things we think may come together, to increase risk within the veteran community as a whole.

Mark (03:58)
I'm wondering if it, it was the number of conflicts that we had since 2001, obviously, you know, nine 11 and, lots of subsequent, engagement around the globe, seemed to be more veterans. I'm wondering if that also played a factor.

Dr. Bryan (04:17)l
Yeah, that was, that was one of the early hypotheses. you know, not long after nine 11, especially around 2006 or 2007 when the military rates started to increase. Interestingly, a lot of research has been done on this and has generally not been able to support that conclusion. and what we're seeing, for instance, is that the majority of service members since nine 11 who died by suicide, were what we call first Termers. They had just joined the military. They were at their first duty assignment. And so those with a deployment history were not necessarily disproportionately, more likely to die by suicide. And so, it took many, many years, but after about a decade of research, it really seemed like that might not actually have been a major contributor. And maybe there were some other issues at play that, honestly, I don't think we've fully figured out yet.

Margaret (05:17)
Well, we, we note, in, some of your work and what we've read, that over half of veterans who die by suicide don't have a known, mental health diagnosis or, or mental illness according to the Department of Veteran Affairs. I, I found that a little bit surprising, to read, but the VA goes on to say that even though mental health, issues can be a factor when it comes to suicide risk, it doesn't paint the full picture, which goes to what you're saying about many factors. I wonder, if you can, speak to the issue we've been reading about, people who are perhaps exposed to, traumatic brain injury risk just from, constant exposure to testing artillery and, issues like that. Has that been identified as a contributing factor?

Dr. Bryan (06:06)
Yeah. So a couple points, I think related to that statistic, so that that, number that you just cited for veterans more than half who die by suicide do not have a known mental health condition or mental illness, is, actually something that is known about suicide as a whole. The same is true amongst civilians. And so in that sense, there's a similarity amongst veterans and non-veterans in terms of risk factors. And what this means is that I think a lot of our historic approaches to how we understand to we could best prevent suicide, at least in the United States, is really focused on mental health treatment, mental health screening, things like that. And I think what, what the statistics there would suggest is that that might be useful for helping out some veterans, but not many others. And so we perhaps need to have a broader perspective on things. and I think one of the things you note there, traumatic brain, Theresa, this is something, that has been identified as another risk factor for suicide, that I, increases risk independence of mental health conditions. I, I published some research years ago when I first got out of the military around this showing that, service members who had a history of multiple traumatic brain injuries over the course of their lives were at increased risk for suicide. This has subsequently been shown to be true in the veteran community more broadly as well as non-veterans. It seems to be something that over the course of the entire lifespan, it might include sports related injuries, car accidents, slips and falls, but also, work related, injuries and accidents, perhaps explosions blast exposure, but also other mishaps that sometimes occur and are oftentimes more common in the military. Another common source of head injuries in the military that, it's often overlooked, is combatives training. you know, just hand to hand self-defense. A lot of people get knocked out while you're learning martial arts, things like that. And so there, there is this, I think, unrecognized and underappreciated risk for veterans that, you know, this injury, these head injuries Oftentimes come part and parcel with the career field itself.

Mark (08:24)
You know, Dr. Brian, I want to talk a little bit about access to mental health services. And I know there was a study Blue Star Family Survey that found one fourth of active-duty US military personnel, say they are not receiving mental health care, but would like to, I'm wondering what more can be done, by the armed forces to, provide mental health services. And we're, we're certainly seeing post COVID an enormous demand for mental health services, really, a a lack of, of, of, staffing for, for the, the, for the demand. But specific to the armed forces, what, what's your thought about, ways that they can, expand mental health support, to veterans?

Dr. Bryan (09:09)
Sure. Yeah. So, a couple years ago, secretary of Defense, Austin commissioned an independent review committee to focus on suicide prevention response in the Department of Defense. And, access to care mental health services was a, a major section on that report. And some of the findings of this independent review commission, where that, of course, we have a national behavioral health shortage. and so just across the United States, we don't have enough counselors and therapists and psychiatrists, and of course, that's, affecting the military as well. there's also been a move, particularly within the military to increase screen, for suicide risk and for other mental health concerns. And unfortunately, decades of research has shown that a lot of the screening tools that we use, tend to identify the wrong people. and so it ends up creating this backlog of demand for mental health care services. And that was one problem identified by this independent review committee, is that in essence, we're using screening methods that perhaps are not particularly effective. And we are flooding the

zone, and so it's hard to get in for an appointment. and so what this means is that perhaps we need to be much more judicious about how we go about, mental health screening, within the military. and then I think a third related issue that's not Department of Defense specific, but perhaps is more broad within the federal government and society, is that right now a lot of veterans are not eligible to receive mental health services from the VA. It's a dirty little secret that most Americans don't know is that under congressional law, the majority of veterans cannot receive health services from the VA. And so part of the reason why more veterans don't get help is because by federal law, they're not allowed, or at least their services are not covered, by our tax stock.

Mark (11:10)
Walk through that a little 'cause, that's, that may be new to some of our listeners.

Dr. Bryan (11:16)
Yeah, yeah, exactly. Yeah. New to a lot of people. I said, it's surprising. I think a lot of us had this assumption, right? That, well, you served in the military and then you get out and you go to the VA for your healthcare. That's actually not true. there are all these rules. It's this very, very convoluted, confusing process, which is why we often hear about, you know, veterans complaining about the review process, to get approved for healthcare benefits. there are rules on, your discharge status. So if you have an other than honorable discharge, federal law says you don't get services from the VA. Hmm. there's even income limits. and so, and if you historically did not have a medical condition or health problem that was directly related or caused by military service, in essence, Congress said, no, we're not gonna provide benefits healthcare coverage for you. So, now that has changed a lot in the past year or two. There have been a lot of movement to open the door for more veterans to PACT Act and the Compact Act, are two different efforts. And, I like to, I call attention to this because I've been out of the military myself for like 15 years, and it was only six months ago that I became eligible for VA services Wow. And had my first VA medical appointment. and so I think there's positive movement we need to continue that moment but that is a hundred percent a congressional issue. Wow. And so my hope is that one of the things your listeners and viewers will take away is that that's something you should be talking with your legislators about.

Margaret (12:50)
Absolutely. Well, thank you so much for sharing with us. I think that that really is news to a lot of people. And as you say, certainly the, development of the community-based primary care centers, for veterans has helped with that. But you have to have the eligibility piece to go with it. Craig, I wanna talk about your work or give you a chance to talk about your work a bit, in developing, a brief form of CBT cognitive behavioral therapy, to use for suicidal military personnel. and you have some evidence to suggest that this can significantly reduce suicide attempts. So tell us about that. How brief is brief, does it, allow for a telehealth approach as well as an indivi- in-person approach? Tell us more about this.

Dr. Bryan (13:37)
Yeah. So, brief in this case, the average or the typical duration of, the treatment protocol is 12 sessions or 12 appointments. And, you know, in most cases, therapy or counseling is scheduled, you know, one hour appointment every week. and so you're typically looking at maybe a, a three, three-month, commitment for the therapy, which is much briefer than a lot of, historic traditional forms of psychotherapy that can be sometimes years in duration, with multiple sessions per week. and so it's a, a, a really significant advance that in essence, within 10 to 12 hours of outpatient therapy, we can lead, to 60% reductions in suicide attempts. It's remarkably effective. we've tested this with military personnel, and published those results. we've since done follow-up research, and we have several new studies that we anticipate being published in the coming year. they're currently under review or in different stages of the publication process. But what we're finding is we're reconfirming those initial, results. And one of the studies, that we have just finished up to answer your question about telehealth, that that was what we did. we tested can we deliver the therapy effectively and safely, virtually over an online video-based platform? and the answer is yes, absolutely. it works. It reduced suicide attempts by 50%. and now actually, a big part of the work that we do here at the Ohio State University, we have a specialty clinic that does nothing but suicide focused care for all adults who are experiencing suicide thoughts. And, around half of the therapy that we provide is virtual, where people are not actually coming into our building, to our clinic face-to-face. We are connecting with them online, in their homes, in their communities, wherever they happen to be.

Mark (15:38)
You, you know, Dr. Brian, in your advocacy, you speak truth to power. And I, and I want, quote something that you wrote in the Hill newspaper, little to No progress in suicide prevention will be made until we directly address the central role of firearms. Nearly 70% of military suicides in 2020 were caused by self-inflicted

gunshot wounds, and almost all of them were from personally owned firearms. So I'm wondering, how, how do you navigate the sort of tricky politics of gun rights and your suicide prevention goals?

Dr. Bryan (16:16)
Yeah, yeah. This is, I've, I've classified this topic sometimes, or characterize it as the third rail. suicide prevention. And it's because, these, these interesting statistics like you just cited here, you know, almost 70% of military and veteran suicides involve firearm. we know that by and large, within the United States, when we look at gun related deaths as a whole, two thirds of them are suicides. And so The topic of suicide and the topic of gun violence, I guess, are these overlapping circles. Right. and it's almost impossible to have a meaningful discussion about either of those things if we don't talk about gun suicide. and so a lot of the work that we've been doing with the military over the past decade has actually been very eye-opening. I think when we first started moving into this space 10 or so years ago, everyone's initial reaction is there's, this is a no go issue. It, it's a non-starter. This, you're gonna piss everyone off. And so why even do this? now, years later, I would say the military and veteran community are absolutely on the leading edge of this, the veteran community I have found to be way more open to this issue. and I think it's because so many of us have lost friends and loved ones, and we're sick and tired of it, and we know that it's a gun related issue, and we know what gun safety is. Yeah. and many of us, you know, we're trained at firing ranges, and we qualified annually or more frequently, and we had all these safety rules when we go to the rage to make sure people don't get hurt, and stay safe. And then a lot of what we talk about now is to take those rules about secure storage, and now just take 'em to our homes and be just as responsible at home as we are at the firing range. And so the way that we, have approached the issue of firearm suicide is to say, we need to lock up our guns at home. Because in the same way that we lock up our cars, or we lock the front doors of our homes to help deter unwanted behaviors, you know, from coming, we can lock up our guns in the same way, which will deter some people in heat of the moment when they're really overwhelmed. that extra step of having to unlock their gun can be enough to actually save their lives.

Margaret (18:45)
Craig, you've highlighted the Department of Defense has implemented several firearm injury prevention strategies, one of which is the distribution of firearm locking devices. But you also point out a severe limitation that Congress has enacted. So tell us about that.

Dr. Bryan (19:03)
Yeah, there was, you know, as part of the, the NDAA, I don't know, it was maybe 10 or more years ago, something like that, can't remember what year it was. It now, there was this provision that was included that had language that in essence, that something along the lines of, that the Secretary of Defense shall not keep records of, which service members own personal firearms, how they store 'em, things like that. And so that was subsequently interpreted as, you're not allowed to ask about guns. You're not allowed to really address, gun related safety. and so this has created a significant barrier for not only commanders and leaders to try to promote safety within their units and ranks, but it's actually been a, a big obstacle for researchers. we, we were doing some studies several years ago, for instance, where we've been trying to understand how do service members store their firearms at home? What do they prefer? What are they willing to do, and what would motivate them to be safe around this topic? And we had a hard time getting, you know, the approvals to ask those types of questions because of this one particular level. and so a lot of time and energy resources have been spent trying to promote firearm safety and secure storage without actually asking about it, without using certain language. and it was this politically contentious issue that, again, the, the initial intent was to protect the Second Amendment rights of service members. So it was well intentioned. and then as is often the case, you know, many, many years later, people interpret the rules and the language in a certain way, and it actually is, has served as a barrier to helping to prevent suicide.

Mark (20:59)
You know, I want to just remind our audience, anybody who's, who's, got any concerns or is, is, contemplating suicide or having, real mental health issues that they can dial 9-8-8, this is a suicide and crisis lifeline. And I'm wondering, Dr. Brian, do explain how this lifeline is specifically helping veterans who call in.

Dr. Bryan (21:29)
Yeah. The, so the lifeline, if you call 9-8-8, which is a national lifeline… it, it used to be this really long one 800 number that no one could remember. And so a few years ago, due to federal legislation, we were able to enact 9-8-8. So it's so much easier to remember. military personnel veterans, when they call 9-8-8, they have the option after the, the system picks up to press one. and it actually redirects call centers in, New York as well as Atlanta, Georgia, a VA trained, crisis counselors. And some of the benefits of this is aside from, you know, being able to listen to help, the caller to try to walk them through whatever they're experiencing right now and listening to

them with empathy, because of the link with the VA, there's also an opportunity in some cases for a veteran to be connected, with an appointment, to have other assistance in providing and receiving healthcare services as well. And so, we, we see it as a really important part of the overall suicide prevention strategy. and it's something that I make sure that all the veterans that I work with as my patients, that they have access. we write it down on a card so that, you know, if they have a dark moment, especially oftentimes it happens in the middle of the night when doctors aren't awake and family members oftentimes aren't awake. there is someone who's awake and they will answer the phone and they'll listen.

Margaret (23:04)
This may be ties, to that, but I really appreciate that part of your research involves studying people who've survived, a suicide attempt. And I wonder, in your research, are there any themes, that you've taken from those, conversations in that research, either in terms of, you know, underlying mental health concerns or pre preexisting issues, or, as you say, the phenomena of, you know, helps not around necessarily in the moment when you need it. Tell us a little bit about what you're seeing.

Dr. Bryan (23:36)
Yeah, I, I would say, I mean, I've learned a lot, so it's hard to sure, kind of pick one, but I, I would say right now, perhaps one of the takeaways of listening and learning from, suicide attempt survivors is, really how often the urge comes very rapidly. And I think we've, we have historically, I think talked about suicide is this incremental process where, you know, people, they get upset and then they wish that they were dead. And then they think about killing themselves and they start to make a plan, and then they start to prepare. Then they give away items and things like that, and then they attempt. but what we have found is that probably more than half of those who attempt suicide describe what we now refer to as rapid intensification. They go from a low risk to a high-risk state, very fast within minutes to hours. and so oftentimes, if there are warning signs, people, family members, friends, loved ones, oftentimes are not around to see it. 'cause it happens so fast. And so this has, this has really, I think, fundamentally shifted how I personally think about suicide and what this means about how to best prevent it. Because I think if we rely only on, here's like a whole bunch of warning signs, and if you see people do these things or you hear them talk about these things, you know, get them to a hospital, something like that, we're gonna miss the majority of veterans who die by suicide. We continue, we will continue to. And then you throw on top of that, you sprinkle in the mix that rapid intensification of risk and easy access to a highly lethal weapon, a loaded weapon, that's a perfect storm for a bad outcome. And so this, I think is another reason why, we've really emphasized and really stressed and heard from survivors that, things like secure firearm storage, locking up your medications, taking other steps to create a safer environment, in some cases will save their lives. Same way that, you know, we buckle up our seat belts when we get to a car, 'cause we never know when we're gonna get to an accident. Right. and it happens suddenly, and it won't prevent the accident, but when you wear that seatbelt, it can save your life. And, and secure storage can do the same,

Mark (26:02)
You know, Dr. Brian, I'd like to pull a little more on the research that you obviously have a really great handle on it, particularly about, world War I veterans who, were suffering from shell shock the term they used for what we now call PTSD. is there something different about the war today that's leading to higher suicide rates?

Dr. Bryan (26:27)
Yeah, that's a good question. I, I guess a honest answer is I don't, we don't fully know. but I do know one thing that is different now that maybe is related, or, or consideration, is, way more, service members survive their interest now then was the case of World War I. And so, as a result, you know, many veterans, have lifelong disabilities, physical limitations. And, despite, you know, despite the ADA, the American Disabilities Act, the world in which we live is not built for people with mobility limitations. Right. and other disabilities. And so it can be a very challenging experience. And so we see a much higher percentage of surviving veterans with, long-term injuries and wounds and medical conditions that a hundred years ago would've killed people, no one would've survived. And so it's a, it's a difference.

Mark (27:26)
And it's so strange think… Yeah. We, we've seen the, the, improvement in terms of emergency room service because of what's happened in the military environment. Right. All of those have transitioned Yeah. Over to your local emergency room, which is probably saving veterans. and what a, what a terrible Yeah. Court knot here, that's gotten tied between those two, factors.

Dr. Bryan (27:54)
Yeah, absolutely. And I mean the, it's the medical advances. It's, you know, evolution of like body armor, other protective equipment as well that has come together. but I, I think your point about, you know, the lessons learned on the battlefields then come back and often benefit all of us who are in severe motor vehicle accidents or, house fires and other horrific experiences like that. I, I, I feel compelled to even, kind of tie a thread where we've had similar translational knowledge on the psychological injury from. So one of the ways that, my, my research and my team has really pushed forward in treating PTSD is to use an approach that is referred to now as mast therapy masked as in like crammed together and, and compressed in a short timeframe. and so the, again, the historic way of doing therapy for someone with PTSD is we meet once a week for months, you know, on end, and hope that things get better. And what we do in the mast format is we meet every single day for two weeks. And so we just compress the therapy into a short window. The idea from this came from the battlefield because when many of us psychologists were deployed to Iraq and Afghanistan, we did not have the luxury of scheduling a Tuesday appointment every afternoon for the next few months. We had to make decisions fast, we had to help people return to the fight, or go home. And so we started cramming the therapy into these really short windows meeting with, injured and traumatized service members daily, multiple times a day. And we found that it worked, and a lot of us military psychologists brought that idea back to the United States, and it's now considered to be one of actually the more effective ways to treat all people with PTSD, veterans and civilians.

Margaret (29:50)
Well, Dr. Craig Bryant, we wanted to thank you for joining us for this important conversation. I think we could continue for quite a while with additional questions, but we're, we're grateful to our audience as well for being here. Be sure to subscribe to our videos on YouTube, find us on Facebook and X with our account name, CHC Radio. And as always, you can go online to CHC radio.com to sign up for email updates, and please share your thoughts and your comments about this program. Craig, thank you so much for your service, for your research, and really groundbreaking efforts. And thank you for joining us today on “Conversations.”

Dr. Bryan (30:26)
Thank you.

Margaret (30:30)