Relationship Between Length of Exposure to Trauma and Mental Illness in the Police

Keywords: Deployment; Police; Military personnel; Mental disorders; Combat disorders

Abstract

Introduction: The activities of the police are considered high risk, because they are exposed to high levels of physical and emotional stress. These work activities can contribute to the emergence of psychiatric disorders that affect their readiness in responding to threats and safety of their actions. Our aim was to conduct a systematic literature review to identify studies that evaluated the time that police officers may be deployed without developing a mental illness.

Materials and methods: Articles published until May 2016 in The MEDLINE (PubMed), Cochrane Library, PsycINFO, and Lilacs databases were searched. In addition, a manual search in the gray literature (theses and dissertations) was also conducted. Several combinations of indexed terms were used in the search of electronic databases, including terms referring to trauma exposure, intervention, and population. There were no restrictions on date and language of the publications. Two reviewers independently assessed studies for eligibility and quality. Disagreements were resolved after consultations with a third reviewer.

Results: Of 905 selected studies, 13 studies evaluated deployment duration and the incidence of mental illness. Studies were excluded because they addressed the prevalence of mental illness but did not relate it to deployment duration or because the studied sample was not the target population of the present study. Studies have shown that a longer deployment time is associated with increased incidence of mental illness. Our analysis of the 13 identified studies indicated the existence of an association between exposure to deployment and mental illness onset.

Conclusion: These findings will be useful to inform and guide future studies conducted in Brazil and worldwide.

Introduction

Previous studies have shown that soldiers may develop Post-Traumatic Stress Disorder (PTSD) after deployment, and the prevalence of stress has increased among deployed soldiers, with those exposed to more intense activities developing higher rates of mental illness [1-4]. The Harmony Guidelines recommend that soldiers should be redeployed every 6 months and should be deployed for no more than 12 months in a period of 36 months. They also state that health problems increase with deployment duration [5-7].

Armed conflicts have characteristics that lead to harmful long-term effects on the health of military personnel, even after they return to civilian life [8,9]. In addition, soldiers generally exhibit higher levels of depression, anxiety, and work-related stress than civilians [10]. However, few studies have addressed the physical and mental health status of police officers, and most of the published studies describe only their daily routines [11-14]. Furthermore, the effects of PTSD are a major concern among decision makers, police officers, and policymakers [15]. Mental illness can compromise the performance of police officers, in terms of their attention and response readiness in performing their duties and responsibilities. Understanding the relationship between the length of exposure to work-related trauma and the occurrence of mental illness contributes to the planning of measures aimed at optimizing the management of military personnel and health care among police officers.

Given the lack of information on deployment duration among police officers, studies that explore these data in more depth are necessary to develop programs targeted at protecting the mental health of police officers who are directly involved in combat.

Methods

This review was conducted in accordance with the recommendations of the manual for systematic reviews and meta-analyses of observational studies in epidemiology (MOOSE) [16].

Eligibility criteria

This review included observational studies (cohort, case-control, or cross-sectional) that evaluated the length of deployment of police officers of both sexes who developed mental illnesses, such as PTSD and depression. Date and language of publication were not considered as exclusion criteria.

Study search

A systematic review was conducted by including studies that were published until May 2016. A search of the journals indexed in MEDLINE (PubMed), Latin American and Caribbean Health Sciences Literature (LILACs), Cochrane Library, and PsycINFO was conducted, and a manual search in the gray literature was also conducted.
Table 1: Bibliographic search conducted in May 2016 to identify relevant studies.

<table>
<thead>
<tr>
<th>Electronic database</th>
<th>Search strategy</th>
<th>Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>LILACS</td>
<td>((mh:(Police)) OR (tw:(Police$)) OR (mh:(Military Personnel)) OR (tw:(Militar$)) OR (tw:(Army$)) OR (mh:(Veterans)) OR (tw:(Veteran$)) AND (tw:(anti-anxiety agents)) OR (tw:(tranquilizing agents)) OR (mh:(anti-anxiety agents)) OR (tw:(tranquilizing agents)) OR (mh:(Antipsychotic Agents)) OR (tw:(Antipsychotic$)) OR (mh:(Hypnotics and Sedatives)) OR (tw:(Hypnotic$)) OR (tw:(Sedative$)) OR (mh:(antidepresive agents)) OR (tw:(Depress$)) OR (mh:(Benzodiazepines)) OR (tw:(Benzodiazepine$)) OR (mh:(Lithium Carbonate)) OR (tw:(Lithium$))) OR (mh:(Mental Health)) OR (mh:(Stress Disorders, Post-Traumatic)) OR (tw:(PTSD)) OR (mh:(Schizophrenia)) OR (tw:(Schizo$)) OR (mh:(Bipolar Disorder)) OR (tw:(Bipolar$)) OR (mh:(Anxiety Disorders)) OR (tw:(Anxiety$)) OR (mh:(Panic Disorder)) OR (tw:(Panic$)) OR (mh:(Depressive Disorder)) OR (tw:(Depress$)) OR (mh:(Combat Disorders)) OR (tw:(Combat$)) AND (mh:(Violence)) OR (tw:(Violence$)) OR (tw:(crime)) OR (mh:(Warfare)) OR (tw:(War$)) OR (mh:(Peace Corps)) OR (tw:(Peace Corps)) OR (mh:(Armed Conflicts)) OR (tw:(Armed Conflicts))</td>
<td>96</td>
</tr>
</tbody>
</table>
### Table 2: General characteristics of the included studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of organization</th>
<th>Participants</th>
<th>Combat site</th>
<th>Type of illness</th>
<th>Data collection</th>
<th>Study duration</th>
<th>Study design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke et al. (2015)⁹</td>
<td>Australian Army, Navy, and Air Force</td>
<td>60228 (cases) 82877 (control)</td>
<td>Vietnam</td>
<td>Mental illnesses and disabilities</td>
<td>Data logging</td>
<td>May 1962 and April 1975 (cases) 1972 and 1994 (control)</td>
<td>Historical cohort</td>
</tr>
<tr>
<td>Brundage (2013)⁷</td>
<td>United States Armed Forces</td>
<td>154548</td>
<td>Iraq and Afghanistan</td>
<td>Mental diseases among other diseases</td>
<td>Post-deployment experiences of all female police officers</td>
<td>October 1, 2001 through December 31, 2010</td>
<td>Cohort</td>
</tr>
<tr>
<td>Bell et al. (2011)⁸</td>
<td>United States Army</td>
<td>4457</td>
<td>Diverse combat zones, including declared wars, police actions, and peace missions.</td>
<td>Mental illnesses and other disabilities (other than mental disabilities) and no disabilities.</td>
<td>Database</td>
<td>January 1994 to December 2007</td>
<td>Case–control</td>
</tr>
</tbody>
</table>
conducted using the parameters described in the eligibility criteria. Strategies were developed specifically for each database and MeSH descriptors were used (Table 1).

To identify any relevant studies published and not retrieved through the initial search strategy, a manual search was conducted of the bibliographic references of selected studies and available systematic reviews. The Brazilian thesis database (Capes) (http://www.capes.gov.br/servicos/banco-de-teses) was also searched.

**Study Selection and Data Collection**

The search criteria were applied to titles and abstracts. The studies retrieved from the electronic databases were collected on a single basis to exclude duplicates. The articles were evaluated by pairs of independent reviewers in two phases: (i) titles/abstracts of identified studies and (ii) complete reading of selected texts. Cases of disagreement between the reviewers regarding the inclusion of the study in the present review were assessed by a third reviewer. Data were collected in duplicate in a previously tested Excel spreadsheet developed for this purpose (Tables 2 and 3).

**Assessment of methodological quality**

The methodological quality of each study was assessed by two examiners, and the divergences were resolved by consensus. For this
purpose, the Newcastle-Ottawa Scale was used for the observational studies, as recommended by the Cochrane Collaboration. This scale judges studies on three major domains: study group selection, group comparability, and assessment of exposure and outcomes of interest. The maximum total score is nine, and scores above six are indicative of quality, as shown in (Table 4). For cross-sectional studies, the methodological quality was not assessed, as this evaluation has not been validated for this type of study.

**Results**

The total number of articles retrieved from electronic databases was 905. The primary exclusion criteria for studies were those that referred to the prevalence of mental illness, specific mental illnesses, combat characteristics, or population that were not of interest. These articles were excluded from the analysis because they did not meet the objectives of this review. After eliminating such studies, 50 studies were selected for complete reading. After this, only 13 studies met all the inclusion criteria and were thus included in the analysis (Figure 1).

Tables 2-4 present information on the general characteristics, main results, and quality assessment of the included studies.

The total of 13 studies included, cohort studies (n = 8), case-control studies (n = 2), and cross-sectional studies (n = 3) studies. The studies by [17,18], and assessed secondary data. The studies by used questionnaires as instruments [19-26]. Used both secondary and questionnaire data. The duration of the studies ranged from 3 to 36 years [27] (Table 2).

In total, 1,689,171 records, interviews, or database entries concerning the association between the exposure of police officers to combat and mental illness were evaluated in the 13 studies included in this review. The total number of records per study ranged from 84 to 1,347,731 (Table 2).

The studies included police officers from four different countries: Australia, United States, Nigeria, and South Africa. The types of organizations included were armed and security forces as well as veteran organizations (Table 2). In relation to the mental illnesses studied, five articles studied only PTSD, whereas the other articles studied mental illness and other disabilities (Table 2).

All studies included in this review assessed the time of exposure to combat. Although no filter for the type of police was used, all the retrieved studies were related to war military personnel, and the exposure to combat was termed deployment, which is defined as overt confrontation. The studies by AFHSC (2011) and MacGregor et al. (2014) evaluated the “dwell time,” which is the time between deployments (Table 3).

Most studies have shown that the longer the deployment, the higher the frequency of mental illnesses, demonstrated that PTSD is lower from the fourth deployment onwards (Table 3).

Okulate and Jones (2006) showed that PTSD was significantly associated with the time spent in the combat area ($\chi^2 = 60.93, p < 0.00$). Emsley et al. (2003) showed that 18% of the individuals who reported a delay in symptom onset following exposure to trauma had significantly longer police service time (Table 3).
Table 3: Information and results of the studies evaluated.

<table>
<thead>
<tr>
<th>Study</th>
<th>Objectives of the study</th>
<th>Diagnosis Methods</th>
<th>Population/sample</th>
<th>Report of findings/Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke et al. (2015)</td>
<td>To evaluate the temporal tendency of disability; compare the results between different types of disability; and assess the frequency and nature of the disability.</td>
<td>ICD-10</td>
<td>60,228 military personnel. 82,877 police officers who had had at least three years of peacetime service in the Australian Defense Force and no experience in overseas deployment.</td>
<td>Standard deployment time: &lt; 100 days Deployment time: between 100–199 days increased the risk of having a mental illness by 2.42 (2.24 to 2.61); having served between 200–364 days increased the risk of having a mental illness by 3.27 (3.07–3.50); and having served more than 365 days increased the risk by 3.53 (3.29–3.79)</td>
</tr>
<tr>
<td>Brundage (2013)</td>
<td>To estimate the percentages of female police officers who were affected by diseases and injuries between the first and third deployment.</td>
<td>ICD-9 through standardized records (hospitalizations or outpatient visits)</td>
<td>154,548 active women who completed at least one OEF/OIF/OND deployment.</td>
<td>Standard deployment time: &lt; 120 days Deployment time: 4-6 months increased the risk of PTSD by 1.17 (10.02-1.34); having been deployed between 6-9 months increased the risk of PTSD by 1.57 (1.38-1.80); having been deployed between 9-12 months increased the risk of PTSD by 1.73 (1.50-2.0); and having been deployed for longer than 12 months increased the risk of PTSD by 2.24 (1.95-2.57).</td>
</tr>
<tr>
<td>Bell et al. (2011)</td>
<td>To assess the role of a) deployment in the combat zone, b) members of the elite force, c) previous hospitalization for mental illness, d) demographic factors, and e) the interaction of these factors in armed forces discharge with mental health disability.</td>
<td>Dichotomous variables for the primary diagnosis of mental health, substance abuse, injury, or other diagnoses.</td>
<td>4,457 Army soldiers with some mental disability. Control group of soldiers with disabilities other than mental health disabilities (8,974). Control group of soldiers without history of disability (9,128).</td>
<td>Standard deployment time: not reported Deployment time: 1-6 months increases the risk of disability by 1.49 (1.33, 1.66), having been deployed between 7-12 months increased the risk of disability by 2.04 (1.84, 2.26), and having been deployed for 13 months or more increased the risk of disability by 2.69 (2.38, 3.04).</td>
</tr>
<tr>
<td>AFHSC (2011)</td>
<td>To evaluate the records of the experiences of deployment in with regard to age, military occupation, and dwell time between repeated deployments</td>
<td>ICD-9 through standardized records (hospitalizations or outpatient visits).</td>
<td>Active members of the United States Armed Forces who returned from OEF/OIF/OND deployment during the study period</td>
<td>Dwell time: The number of soldiers diagnosed with PTSD and anxiety disorder increased with the dwell time that preceded the second and third deployments when compared with the first deployment; PTSD was smaller in the fourth and fifth deployments than in the third deployment.</td>
</tr>
<tr>
<td>MacGregor (2014)</td>
<td>To assess the effect of dwell time and the occurrence of psychological outcomes among Navy combatants with two deployments.</td>
<td>A health screening questionnaire was used to identify health problems.</td>
<td>Active members of the United States Navy, identified from electronic records, diagnosed with PTSD and depression.</td>
<td>Dwell time: The mean duration of the first deployment was 207 days; of the second, 205 days. The mean dwell time was longer than the duration of the first deployment, with a median of 338 days. The strongest predictor for both PTSD (OR 2.28, 95% CI 2.00 to 2.59) and depression (OR 1.30, 95% CI 1.11–1.53) was having been exposed to combat.</td>
</tr>
</tbody>
</table>
### O'Toole et al. (2009)\(^2\)

#### Objective
To assess the physical and mental health of veterans after the war and to compare them with the Australian population. To examine the relationships between military aspects, service in Vietnam, and PTSD in veterans.

#### Design
ICD-10

#### Participants
450 Australian veterans who were in combat in Vietnam (case) and the General population of Australia (control).

#### Results
Police Navy officers who returned from deployment in the period between 2002 and 2006 and who completed the post-deployment health assessment.

#### Standard deployment time: not reported.

#### Deployment time: service duration was primarily associated with moderate depressive disorders (5.61 [1.26–5.04]), and a diagnosis of PTSD (3.59 [4.48–8.66]), in the first set of interviews (21.96 years after the mission). In the second set of interviews (36.2 years after), recurrent severe depression (F33.2; 5.48 [1.23–24.32]), and diagnosis of PTSD (3.17 [1.20–8.41]) were observed.

### Shen et al (2009)\(^2\)

#### Objective
To assess whether site and duration of deployment influences the incidence of PTSD.

#### Design
Diagnosis of PTSD according to at least two positive responses in the PC-PTSD

#### Participants
Police Navy officers who returned from deployment in the period between 2002 and 2006 and who completed the post-deployment health assessment.

#### Standard deployment time: not reported.

#### Deployment time: not reported.

### Okulate et al (2006)\(^2\)

#### Objective
To assess the relationship between exposure to trauma and duty and onset of symptoms in individuals diagnosed with PTSD.

#### Design
PTSD assessed through a checklist.

#### Participants
All hospitalized patients who participated in military operations over a period of four years (1990–1994) and who were physically fit to be evaluated.

#### Standard deployment time: not reported.

#### Deployment time: PTSD was significantly associated with the time spent in the combat area (x\(^2\) = 60.93, p < 0.00). In the multivariate regression analysis, the independent variable that was most associated with PTSD was time in combat (p = 0.007, odds ratio (OR) 3.32, 95% CI: 1.31 - 4.52).

### Adler (2005)\(^7\)

#### Objective
To evaluate the effect of deployments on the psychological health of police officers

#### Design
SDS, Post-Traumatic Stress Scale DSM-IV

#### Participants
United States soldiers in mission in the Bosnian area of operations.

#### Standard deployment time: not reported.

#### Deployment time: Significant relationship of 0.10 (p < 0.01) between the number of months deployed and increased score on the depression scale in men. PTSD scores for men increased with time of deployment (r = 0.14, p < 0.01).

### Grieger et al. (2006)\(^2\)

#### Objective
To examine rates, predictors, and the incidence of PTSD and depression.

#### Design
Patients who met DSM-IV criteria.

#### Participants
Seriously injured Army soldiers during and after hospitalization.

#### Standard deployment time: not reported.

#### Deployment time: soldiers with longer exposure to combat were 4.8 times more likely to develop PTSD at 1 month (95% CI = 1.6–14.4; Wald x\(^2\) = 7.74, DF = 1, p = 0.005). Exposure to combat was not significantly associated with the risk of PTSD or depression at 4 or 7 months.

### Emsley, et al (2003)\(^2\)

#### Objective
Evaluate the relationship between trauma exposure and the onset of symptoms in patients diagnosed with PTSD

#### Design
Patients who met DSM-IV criteria.

#### Participants
Members of the South African Security Force permanently retired due to a diagnosis of PTSD.

#### Standard deployment time: not reported.

#### Deployment time: Age was significantly correlated with service time (r = 0.85, p = 0.0001), exposure to trauma prior to the onset of symptoms (r = 0.772, p = 0.001), presence of a psychiatric disorder (r = 0.20, p = 0.03), and contribution to PTSD symptoms (r = 0.75, p = 0.001). The 22 individuals (18%) who reported a delay in symptom onset following exposure to trauma had significantly longer police service time (t = 2.1, df = 33, p = 0.048).
study assessed the percentage of police officers affected by mental illness. The study by also included a police unit from the United States deployed to the same place of combat; however, the researchers only studied PTSD and their aim was to assess whether location and deployment duration influenced PTSD incidence. The shortest deployment duration was studied by, who reported an association with PTSD from 61 days of deployment onwards.

According to the data in (Table 2), some conclusions were presented by the authors of the studies: and defined <100 days and <120 days, respectively, as the maximum deployment time. The other studies did not define a standard deployment time.

Discussion

Military personnel need to receive high-performance physical preparation, develop weapon skills, and be psychologically prepared to become capable for overt confrontation (deployment). However, even for those who are well prepared, the length of exposure to deployment is likely to bring direct and indirect consequences to the person and to the unit. In this study, it was possible to determine that one of the main impacts is mental illness, which is often overlooked in the literature.

This statement refers especially to military personnel; of the 905 studies, 890 focused on mental illnesses related to other traumas, predominantly stress, and on other populations such as entrepreneurs, teachers, and politicians. Thus, it is necessary to clarify that although there is academic research addressing mental illnesses arising from traumas and situations of stress, there is a specific lack of studies focusing on the police population.

Among the 13 studies identified, eight were conducted with American military personnel, including veterans and army, navy, air force, and armed forces personnel. The other studies included military personnel from South Africa, Nigeria, and Australia.

The combat zones varied; however, with the exception of the study, which comprised various conflict areas, including police actions and peacekeeping missions, all other studies focused on war zones. The study by had the longest time frame, from 1962 to 1994, assessing Australian military personnel who went to combat in Vietnam. These studies reported the mental illnesses and disabilities that were closely linked to those specified in ICD 10. Thus, although the studies focused on the military population and found a prevalence of mental illnesses, these were not the only focus and were included among other pathologies and limitations caused by war settings.

The studies by associated PTSD incidence with deployment duration; the longer the time of service with exposure to trauma, the greater the delay in the onset of PTSD-related symptoms. In the second study, in which interviews were conducted 36 years after the mission, the diagnosis of PTSD was lower. Most studies focused on assessing the experiences of deployment through questionnaires; this may be a limitation of studies conducted with military personnel, as was previously mentioned.

The studies differ in terms of population and objectives. The earlier study included all police officers in the United States military, whereas the study included only female police officers. The first study aimed to assess deployment and dwell time experiences. In turn, the second study assessed the percentage of police officers affected by mental illness. The study by also included a military unit from the United States deployed to the same place of combat; however, it only focused on PTSD and the aim was to assess whether location and deployment duration influenced PTSD incidence. The
Table 4: Assessment of the quality of the articles using the Newcastle–Ottawa scale.

### Newcastle–Ottawa Scale – Cohort

<table>
<thead>
<tr>
<th>Studies</th>
<th>Selection</th>
<th>Comparability</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Representativeness of the sample in the exposed cohort</td>
<td>Ascertainment of exposure</td>
<td>Demonstration that the outcomes of interest were not previously determined at the start of the study</td>
</tr>
<tr>
<td>Clarke et al. (2015)</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Brundage (2013)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>O’Toole et al. (2009)</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Shen et al. (2009)</td>
<td>1</td>
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<tr>
<td>AFHSC (2011)</td>
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<td>1</td>
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<tr>
<td>MacGregor (2014)</td>
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<td>1</td>
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<tr>
<td>Branchey (1990)</td>
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<td>1</td>
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<tr>
<td>Grieger et al. (2006)</td>
<td>1</td>
<td>1</td>
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</table>

### Newcastle–Ottawa Scale – Case–Control

<table>
<thead>
<tr>
<th>Studies</th>
<th>Selection</th>
<th>Comparability</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Representativeness of cases</td>
<td>Definition of controls</td>
<td>Comparability of cohorts and controls on the basis of the design or analysis</td>
</tr>
<tr>
<td>Bell et al. (2011)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Okulate et al. (2006)</td>
<td>1</td>
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</tr>
</tbody>
</table>
shortest deployment time was studied by Shen et al. (2009) who found an association with PTSD from 61 days of deployment onwards.

Although the studies present contradictory results in relation to the deployment time that military personnel can withstand without any damage to their mental health, they all agree that the longer the deployment time, the greater the risk and incidence of mental illnesses, and the greater the likelihood of developing more severe pathologies, as shown in the studies. This finding also occurs when the military personnel has a dwell time, i.e., a period at home before another deployment. In this case, and according to, the military personnel begin to show signs of mental illness after the second or third deployment.

An interesting feature was noted in the study by, who stated that police and/or military personnel with longer careers before deployment usually present a later onset of mental pathologies than those less experienced who are exposed to combat.

The following conclusions were presented in the studies: defined <100 days and <120 days, respectively, as the maximum deployment time that military personnel can withstand. The other studies did not define standard deployment times.

Considering the limitations of reality in terms of police actions in different countries, the minimum exposure time at combat was calculated on the basis of the data presented in those studies. In this perspective, the maximum time officers can be exposed to deployment without developing mental illness would be up to 30 days.

Although the study by, presented mental disorders associated with other pathologies resulting from deployment, the remaining studies show that, regardless of the presence of sequelae, military personnel are very prone to developing or having a recurrence of mental illness after deployment.

Final Considerations

In this review, it was observed that, although military personnel are an essential professional class for the maintenance of social order, requiring good mental health to adequately perform their activities, few studies have investigated the consequences of exposure of these officers to deployment. However, the studies that assessed the consequences of such exposure to mental burden confirmed the occurrence of behavioral mental disorders; the most commonly observed conditions were depression, obsessive disorders, and excessive anxiety.

One possible explanation for the lack of research involving the military is the difficulty in accessing records and data, mainly because of the confidentiality and security protocols adopted by the military organizations.

Of the 905 studies that associated behavioral disorders with stress situations, only 13 addressed the topic of this review and could therefore be included. These 13 studies agree on the existence of an association between exposure to deployment and mental illness onset.

The retrieved data suggested that the longer the military personnel are exposed to deployment, the greater the incidence and prevalence of mental illnesses. These can range from mild to severe in nature. However, most studies focused solely on the research of the relationship between deployment time and mental illness and did not look more deeply into the extent of these diseases, the need for drug therapy, or duration of treatment after the diagnosis of mental illness, whether it was depression or milder behavioral disorders such as anxiety.

In addition to the lack of studies on this population, one of the main limitations of the present review was the lack of studies that describe, in a specific and detailed manner, the diseases, their treatments, and drug therapies, as well as the intrinsic and extrinsic consequences of these conditions to military personnel.

Overall, this study has implications for understanding the causes of post-traumatic stress in the police environment and can help decrease the incidence of stress in the military services. Moreover, this study provides a basis for military leaders to establish programs to improve assessment, prevention, and intervention measures.

Data from this study suggest that military leaders should provide continued support to the personnel during and after deployment, as well as adequate treatment before the problems become chronic and cause damage to society and the military unit. This is especially important with regard to the Brazilian armed forces, because no studies investigating the complications and/or consequences of mental illness after deployment of Brazilian military personnel were retrieved.

References


