



Posttraumatic Stress: Revisited

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Introduction

Over a year ago, ValueOptions sent out a mailing to all TRICARE network behavioral health providers encouraging them to be aware of the diagnosis and treatment of PTSD in the returning veteran. As time has passed and the conflicts in the Middle East have continued, more and more evidence is available regarding the incidence of behavioral health symptoms after being deployed. Postdeployment symptoms in Army soldiers and Marines have ranged from 11.3% in Afghanistan to 19.1% in Iraq [1]

The Department of Defense has been aggressively focusing on the diagnosis and treatment of behavioral health disorders in returning servicemen and women, especially symptoms related to trauma. This focus includes postdeployment screenings, reassessments and innovative treatments. One cutting edge treatment is being pioneered at the Naval Medical Center San Diego. This study involves using virtual reality exposure therapy as an alternative to traditional psychotherapy. A number of other resources have become available for the military population including an anonymous mental health screening tool available at www.militarymentalhealth.org.

In addition to the Department of Defense, the Veteran's Administration (VA) has a variety of resources available. The VA has long been a leader in research and treatment of Posttraumatic Stress symptoms. A wealth of information can be obtained at the National Center for Posttraumatic Stress Disorder (www.ncptsd.va.gov). This website has useful information for providers, beneficiaries and family members.

It is important to be aware of the effects that postdeployment behavioral health symptoms may have on the family members of a returning service member. Education of these family members is of utmost importance. Many times, the service member does not recognize there is a problem and it may be necessary for the family to assist in getting an evaluation and possible treatment for their loved one. Helping the family access assistance for the service member can be very therapeutic to the whole family structure.

One change in the military's current approach surrounding the diagnosis and treatment of posttraumatic symptoms is to not jump to the diagnosis of PTSD. Many times the posttraumatic symptoms experienced are normal reactions to very abnormal situations. Military medicine has taken a watchful waiting approach since many symptoms may lessen over time and thus avoid labeling a warrior with a pathologic diagnosis. Service members are assessed upon return (Post Deployment Health Assessment) and at approximately 6 months (Post Deployment Health Reassessment) with follow-up as appropriate. Another innovative program that is being pioneered at Walter Reed Army Institute of Research is the BattleMind program (www.battlemind.org). This program



addresses the many symptoms related to posttraumatic stress and includes videos, brochures and other presentations.

As previously mentioned, posttraumatic symptoms can present in a continuum of severity and duration. The following summary revisits the criteria and treatment of “full blown” posttraumatic symptoms consistent with the DSM IV-TR diagnostic criteria for PTSD.

Diagnosis

To accurately diagnose PTSD, the individual must have been exposed to significant trauma that involved risk of injury or death to themselves or others and they responded with intense fear or helplessness. The trauma is persistently reexperienced as intrusive recollections, images, thoughts, dreams, dissociative flashbacks or intense reactions to situations that resemble an aspect of the traumatic event.

The affected individual will avoid things associated with the trauma (or respond in a numb manner). A patient may display general avoidance of all activities, a restricted ability to experience emotion and an inability to recall certain aspects of the trauma.

Other less specific symptoms may also be present. These include increased arousal and startle response, difficulty sleeping, irritability and poor concentration. Many times there is guilt, coexisting depression, panic disorder or substance abuse.

For PTSD to be diagnosed, the symptoms must be present for at least 1 month accompanied by significant impairment in functioning. PTSD can be acute if the symptoms last less than 3 months, or chronic if they last longer. In addition, symptoms can be delayed, with onset greater than 6 months after the trauma (perhaps months to years after the active duty service member returns home).

The rate of PTSD appears to increase with the severity of the trauma experienced. The Epidemiologic Catchment Area (ECA) study indicated that 4% of Vietnam veterans who had not been wounded developed PTSD, where as up to 20% who had been wounded developed PTSD. More recent data reveals that the number of firefights a service member was involved in correlates with the incidence and severity of symptoms. It appears that as the number increases to 10, the incidence increases and then begins to level off some. It is important to remember that not all trauma related to deployment is combat related. There are many instances of motor vehicle or other accidents that are significant traumatic experiences which could lead to PTSD. In addition, it is important to realize that a significant percentage of Posttraumatic Stress symptoms in female service members may be related to sexual trauma.



There are a number of tools that can be utilized to assist in the evaluation and diagnosis of PTSD. These screening tools can be found at the National Center for PTSD website listed above.

Treatment

There are a number of medications and therapies that can be effectively utilized in the treatment of PTSD. Pharmacologic agents have been found to have varying effectiveness on PTSD symptoms. These include selective serotonin reuptake inhibitors, tricyclic antidepressants, monoamine oxidase inhibitors, clonidine, lithium, carbamazepine, valproic acid, lamotrigine, triiodothyronine, buspirone and trazadone.

Psychotherapy is also an integral part of the treatment of PTSD. Crisis intervention delivered immediately after the traumatic incident has recently been under scrutiny. A supportive environment is important, but some literature indicates formal critical stress debriefing is of questionable benefit [2]. Both group and individual/family therapies can be helpful. Cognitive, behavioral and brief dynamic therapies have also been found to be beneficial in the treatment of PTSD. These can include systematic desensitization, exposure with response prevention, thought stopping and relaxation techniques.

The American Psychiatric Association has compiled evidence based guidelines on the treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. These can be viewed at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

Summary

During this time of stress and the continued high rate of deployments for the active duty military and their families, providers treating TRICARE beneficiaries must be aware of the possibility of PTSD. In addition to the websites listed above, there are many more resources available to the clinician screening for and treating PTSD. Also, ValueOptions peer reviewers can be accessed on a consultative basis on these types of cases by calling 800-700-8646.

[1] Hoge, Charles et. al. *Mental Health Problems, Use of Mental Health Services and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan*, Journal of the American Medical Association, Volume 295, No. 9, March 1, 2006, pp. 1023-1032

[2] M. Arendt, A. Elklit (2001) *Effectiveness of Psychological Debriefing*, Acta Psychiatrica Scandinavica, 104 (6), 423-437