

# Identifying and Treating Post Deployment Mental Health Problems Among New Combat Veterans

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North Carolina is one of the nation's most military friendly states because it is home to more than 101 000 active-duty military personnel at Fort Bragg, Pope Air Force Base, Camp Lejeune Marine Corps Base, Seymour Johnson Air Force Base, the US Coast Guard Air Station at Elizabeth City, and Marine Corps Air Stations at New River and Cherry Point. In addition, North Carolina has 164 Army and Air National Guard units comprised of nearly 12 000 members as well as another 10 234 Army, Navy, Air Force, Marine, and Coast Guard reservists.<sup>1</sup> North Carolina-based military units have played an important role in the Global War on Terror including multiple deployments to Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF). Many servicemen and women have families in the state and many choose to make North Carolina their home when they become veterans. The effects of war reverberate across our state and within each of our local communities.

## Treating Post Deployment Mental Health Problems in Community Settings

While it might be natural to expect that any post deployment mental health problems of service members and veterans would be identified, assessed, and treated within the Department of Defense (DoD)/Department of Veterans Affairs (VA) medical care continuum, the available data suggest otherwise. Hoge and colleagues from the Walter Reed Army Institute of Research<sup>2</sup> found significant reticence to discuss post deployment mental health problems in military settings among service members who had served in OEF/OIF. The National Vietnam Veterans Readjustment Study<sup>3</sup> showed that only 20% of

Vietnam veterans with a diagnosis of posttraumatic stress disorder sought VA care. Thus far, only about 1 out of every 3 OEF/OIF veterans eligible for VA care has applied for that care. Taken together, these findings indicate that many OEF/OIF veterans may seek care outside of DoD and VA. Their family members are also subject to significant deployment-related

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stress, and they too will be seeking help in the greater community. The stigma associated with seeing a mental health provider will often drive combat veterans and their family members to seek help in primary care settings, but primary care practices are not always well prepared to identify or treat such problems.<sup>4</sup> This

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article provides essential information on screening for, assessing, treating, and, when necessary, triaging disorders associated with military deployment.

## Screening

Posttraumatic stress disorder (PTSD) is characterized by a constellation of symptoms that follow exposure to an extreme traumatic event which involves actual or threatened death or serious injury.<sup>5</sup> The response to the event must include intense fear, helplessness, or horror and symptoms that persist more than one month including (1) reexperiencing the traumatic event through intrusive recollections, dreams, or nightmares; (2) avoidance of trauma-associated stimuli such as people, situations, or noises; and (3) persistent symptoms of increased arousal which may include sleep disturbance, hypervigilance, irritability, or an exaggerated startle response. A PTSD diagnosis must also be accompanied by clinically significant distress and a decline or impairment in social, occupational, or other important areas of functioning.

A structured clinical interview such as the Clinician Administered PTSD Scale<sup>6</sup> (CAPS) is an optimal assessment for PTSD and has long been the gold standard for making that diagnosis in clinical studies. However, detecting possible PTSD at the population level or within a large cohort of returning combat veterans is best approached with a brief, optimally sensitive measure which minimizes false negatives while efficiently identifying those in need of further assessment.

**Table 1.**  
**The Primary Care Posttraumatic Stress Disorder Screen (PC-PTSD)**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?  
YES / NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?  
YES / NO
3. Were constantly on guard, watchful, or easily startled?  
YES / NO
4. Felt numb or detached from others, activities, or your surroundings?  
YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items.

The 4-item Primary Care PTSD screening tool (PC-PTSD)<sup>7</sup> has been adopted by both DoD and VA due to its brevity and sensitivity. It was developed specifically for application in primary care settings and has been incorporated into both DoD's Post Deployment Health Assessment (PDHA), performed at the time of return from a combat area, and its Post Deployment Reassessment (PDHRA), performed 3 to 6 months after return. The Primary Care PTSD screening tool has also been incorporated

into VA's computerized medical record system as a pop-up reminder on all OEF/OIF veterans registered for VA health care. This valuable screening tool is in the public domain and can be a useful aid in medical practices outside of DoD and VA.

While a score of 3 positive answers or more is required to trigger further action in VA settings, we advise that any positive response to a Primary Care PTSD question should spur further follow up from health care providers even if only to ask basic questions about personal and family readjustment following deployment. Most service members and veterans will not meet diagnostic criteria for any mental disorder and yet all of them are dealing with significant readjustment stress (as are their families). The object of screening is not simply to rule in or rule out a diagnosis of PTSD: it is to learn more about other common post deployment medical problems (eg, substance abuse, major depression) and to identify significant functional problems including job stress, unemployment, family stress, and homelessness. Combat veterans may report anxiety, sadness, loss of interest in work or recreation, or inordinate fear for the safety of family members and friends. Psychological trauma may surface indirectly as an exacerbation of chronic physical ailments such as shortness of breath in an asthmatic or increased pain in a person with arthritis. It may be expressed in new somatic symptoms (eg, headaches, abdominal pain) or as new or exacerbated substance abuse. It may lie veiled behind vague complaints of poor energy or poor sleep. Problems with memory, concentration, emotional lability, or irritability may also suggest traumatic brain injury which might then trigger further screening such as the 3-Question Screening Tool developed by the Defense and Veterans Brain Injury Center.<sup>8</sup>

Perhaps the most basic and most important screening step is simply to ask patients, "Are you a veteran or are you the family member of a veteran?" This question may be key to understanding why this particular patient is coming to see you and why now.

If a patient scores a 3 or higher on the Primary Care PTSD screening tool, a good follow-up instrument for further assessment would be the PTSD Checklist, Civilian Version (PCL-C).<sup>9</sup> This 17-item self-report measure covers each of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) symptoms of PTSD. Patients are asked whether they were "bothered by that problem in the past month" and responses are scored on a 5-point scale ranging from 1 ("not at all") to 5 ("extremely"). Available in several forms, the PTSD Checklist, Civilian Version is recommended for post deployment screening because, unlike the military version, it is not focused on any one specific traumatic event. This allows the respondent to make connections to a broad range of deployment experiences, any one of which might be the key stressor for that individual. The PTSD Checklist can be scored in different ways; a total score (range 17-85) can be obtained by summing the scores from each item or the responses can be reviewed to establish that DSM-IV criteria for PTSD

have been met. Hoge et al<sup>2</sup> employed a cut-off score of 50 as a conservative indicator for a positive diagnosis of PTSD.

## Treatment

A recent review of the evidence base for psychotherapies and psychopharmacological strategies in the treatment of PTSD among combat veterans by the Institute of Medicine of the National Academies<sup>10</sup> suggested that more research is needed before all but one of these can be recommended at the highest level of confidence (exposure therapy being that single exception). Having acknowledged that finding, a number of clinical practice guidelines exist to assist clinicians in learning about available treatments, reviewing their evidence base, and making practical, patient-specific choices among them.

Most relevant among these is the VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress.<sup>11</sup> Created by a joint working group of VA and DoD clinicians and researchers, this comprehensive guideline provides clinical algorithms that walk clinicians through the necessary steps from screening and initial assessment through treatment and reassessment. Separate algorithms are defined for primary care providers and mental health professionals. Evidence tables are provided for each recommendation and a substantial literature review is included. This guideline is available on the Internet ([http://www.oqp.med.va.gov/cpg/PTSD/PTSD\\_Base.htm](http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm).) and is in the public domain.

The American Psychiatric Association has published the Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder.<sup>12</sup> The International Society for Traumatic Stress Studies, the world's largest international multidisciplinary professional organization working in the field of psychological trauma, provided a comprehensive set of treatment guidelines in 2000<sup>13</sup> with a new edition expected in 2008. Both guidelines provide a thoughtful introduction to available therapies, significant background information, and evidence-based treatment recommendations.

A thorough review of these treatments is beyond the scope of this paper, but a brief summary statement of the most highly recommended modalities (based on the VA/DoD guidelines) may prove helpful. Among the psychotherapies, prolonged exposure therapies (based on behavioral principles including habituation and extinction), cognitive behavior therapies (focusing on correcting misattributions and maladaptive responses), and Eye Movement Desensitization and Reprocessing (believed to facilitate psychological and neurological processing of traumatic events) have the strongest evidence base. The use of psychodynamic psychotherapy (derived from psychoanalytic principles) is supported by at least one randomized control study but does not have as strong a research base. Little evidence exists to support the use of Critical Incident Debriefing in the prevention of PTSD, and there is some evidence suggesting that debriefing activities can actually increase the risk of PTSD by retraumatizing survivors who are not prepared to be reexposed to horrific memories.

Among the medications available for the treatment of PTSD, specific serotonin reuptake inhibitors and venlafaxine have the strongest evidence base. While many drugs from a wide range of classes have been studied in PTSD, there is little evidence to support their use except as adjunctive treatment. Available research suggests that prazosin reduces the frequency and intensity of posttraumatic nightmares and may be effective in managing other symptoms of PTSD, but it cannot yet be recommended as a stand-alone treatment. There is evidence that benzodiazepines are not effective as first line agents in the treatment of PTSD. Because of their potential for dependence and abuse, their use as single agents is strongly discouraged in the VA/DoD guidelines.

## Accessing Additional Support

Clinical practice guidelines are of significant value in the management of PTSD. Similar guidelines for disorders that are frequently comorbid with PTSD are also available through their respective DoD/VA work groups and the American Psychiatric Association among other authoritative sources. As noted earlier, many of the problems faced by returning combat veterans and their families are not specifically clinical: they may best be conceptualized in functional terms (eg, work stress, unemployment, educational/training needs, housing needs, financial and/or legal problems), and family terms (eg, lack of social support, estrangement, family breakup). Veterans, their family members, and their practitioners may find it helpful to consult a unique service available in North Carolina: NCcareLINK.<sup>14</sup> NCcareLINK (<http://www.nccarelink.gov>) is a comprehensive health and human services Web site offering information services and bilingual support that connects patients and their care givers with over 10 000 agencies and services across our state. Administered by the North Carolina Department of Health and Human Services, NCcareLINK was developed in partnership with DoD, VA, and state and community entities following recommendations made by the North Carolina Governor's Focus on Returning Veterans and their Families.<sup>15</sup> People who are unable to access the Web-based service may call the toll-free telephone counterpart NC CARE-LINE (1-800-662-7030). Established in 2006, NC CARE-LINE will soon begin operating 24 hours per day 7 days per week.

North Carolina has a great stake in the post deployment health of military personnel, veterans, and their families. An impressive network of programs, services, and information systems stands ready to support these citizens and their health care providers in retaining and/or regaining their highest potential for health and function. Optimal health and function cannot, however, be attained unless key questions are asked throughout our entire health system. The first and most basic of these is "Are you a veteran or the family member of a veteran?" With this information in hand, effective work can begin. **NCMJ**

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*If you work in a health care setting . . .*

# Get a Flu Shot!

**Or Nasal-Spray Vaccine\***

## Protect Yourself

You are likely to be exposed to flu at work. If you don't get flu vaccine, you can catch the flu and become very sick. The flu is a lot worse than a cold.

## Protect Your Family

You can spread the flu even before you feel sick. Your family and friends could become seriously ill, especially babies and older adults. Likewise, your family and friends could miss days of school or work.

## Protect Your Patients

You can also spread the flu to your patients. For some patients, flu can be a life threatening disease.

\* If you are under 50 and are not pregnant, you can get the nasal-spray vaccine instead of a shot. However, do not get the nasal-spray vaccine if you have a chronic disease like asthma or diabetes, or work in a hospital isolation unit.

**Have questions?** Visit [www.immunizenc.com](http://www.immunizenc.com) or call the

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