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Horror comes home

Veterans with posttraumatic stress disorder

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The wife of a 25-year-old Veteran sees their family physician, concerned about her husband. He recently released from the Canadian Forces (CF), and she reports that he is not coping well. He has difficulty sleeping, seems irritable, and has angry outbursts. During military service he was deployed twice to combat theatres. Both times he returned home "not the same man." He worked "outside the wire," managing acutely injured combatants. Their patrol was struck by an improvised explosive device, severely injuring several soldiers and killing 2. While he was still serving, she had urged him to speak to his medical officer, but he denied having problems. The family physician encourages her to book another appointment and bring her husband. She also contacts the Operational Stress Injury and Support program (OSISS). The OSISS peer-support coordinator encourages the Veteran to follow up with his family physician.*

After history, physical examination, and appropriate investigations, the family physician rules out other physical conditions and suspects posttraumatic stress disorder (PTSD). The Veteran remains sceptical, but with motivational interviewing agrees to a referral for mental health assessment and follow-up visits with the family physician. The physician urges him to call Veterans Affairs Canada (VAC), and with his consent sends a referral letter to the local VAC District Office. He is referred on to a VAC Operational Stress Injury Clinic, where he is diagnosed and treated for PTSD, in collaboration with his family physician. The OSISS peer-support coordinator maintains contact with the Veteran and his family. The Veteran applies for a disability award.

Posttraumatic stress disorder secondary to military psychological trauma occurs in a substantial number of Veterans, and they might present to family physicians with complex physical and psychiatric comorbidities.¹ The current and lifetime prevalences of PTSD among serving CF members are about 2.8% and 7.2%, respectively.² In a sample of Canadian peacekeeping Veterans receiving pensions after being diagnosed with medical conditions, a 1-month prevalence of probable PTSD of 10.3% was reported.³ In samples of US military members, following deployment to Iraq and Afghanistan the rates of PTSD were estimated to be between 11% and 17% compared with a baseline rate of 5% before deployment.⁴ In a sample of UK military members, the reported rates were considerably lower at 4.8%.⁵

*The case presented is fictitious.

Detecting PTSD


While service-related PTSD is often diagnosed during military service, some Veterans might not seek help until after releasing from service.⁶ Presentations of military-related PTSD are often complex. Veterans might present indirectly with emotional, behavioural, or addiction concerns, or with unrelated, less stigmatizing somatic problems such as physical complaints.⁶ Two factors in the history should trigger the physician to consider PTSD in the differential diagnosis: *previous exposure to psychological trauma and presence of any PTSD symptoms*. Patients with PTSD present with 3 symptom clusters: reexperiencing, avoidance and numbing, and hyperarousal symptoms.¹

Understanding military culture and the nature of military deployments is essential to detecting PTSD and establishing a trusting therapeutic alliance. Potentially traumatic events (PTEs) experienced by those in the military can differ from those experienced by the general community. In the general community, PTEs typically involve rape, motor vehicle accidents, assault, natural disasters, or terrorism. Military PTEs also include combat, imprisonment, torture, witnessing atrocities, comrades being wounded or killed, or rescue missions following natural disasters.⁷ Military personnel are more likely to be exposed to psychological trauma than the general public are.⁸ Patients with PTSD are prone to presenting with somatic symptoms¹ and are high users of health care resources.³ Family physicians should screen for possible PTSD in former military members.

Delays in accessing care might contribute to the functional impairment often associated with PTSD. "Macho" military identity and fear of stigmatization are barriers to seeking treatment, especially at an early stage when symptoms might be more likely to respond to treatment.⁹

Diagnosis and screening

Box 1^{6,10,11} suggests an approach for family physicians seeing previously undiagnosed Veterans. The signs and symptoms of PTSD are nonspecific, so initially the differential diagnosis of presenting symptoms might include both physical and mental disorders.¹² Check for physical, psychological, and social symptoms, inquire about exposure to military psychological trauma, then work through the differential diagnosis.¹³ While no physical condition explains

 La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro de mai 2010 à la page e169.

Box 1. Approach to recognition and initial investigation of possible posttraumatic stress disorder (PTSD) in military Veterans

Features suggesting possibility of PTSD

- Previous exposure to 1 or more mentally traumatic events and
- 1 or more symptoms characteristic of PTSD:
 - intrusive images and sensations
 - arousal, hypervigilance, startle, sleep difficulty, nightmares, and flashbacks
 - avoidance, social withdrawal, and emotional numbing
 - associated symptoms including but not limited to depression and cognitive difficulty
- Previous military service, particularly conflict deployments
- Patient, family, or friends attribute symptoms to PTSD

Primary Care PTSD Screen (positive if patient answers yes to any 3 items)

- "In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you ...
 - have had nightmares about it or thought about it when you did not want to?
 - tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
 - were constantly on guard, watchful, or easily startled?
 - felt numb or detached from others, activities, or your surroundings?

Differential diagnosis

- Physical health conditions:
 - thyroid, other endocrine, neurologic, hematologic, and metabolic disorders
 - persistent symptoms following previous traumatic brain injury
 - medication effects or complications of substance disorders
 - sleep disorders
- Mental health conditions:
 - depression, anxiety, psychosis, and somatoform, personality, and substance disorders

History and physical examination

- Explore presenting complaint, review of systems, social relationships, and family functioning
- Consider substance abuse and other addiction (eg, gambling), interpersonal safety, and suicidal or homicidal thoughts
- Physical examination guided by symptoms and history; include cognitive assessment

Investigations

- Laboratory:
 - thyroid screen
 - consider urine drug testing or screening
 - consider other laboratory investigations depending on the presentation
- Neuroradiology: Depending on presentation and likelihood of intracranial lesion
- Neurocognitive testing: Consider for suspected cognitive difficulty or a previous history of head or brain injury
- Sleep studies: Consider if primary sleep disorder suspected or sleep does not improve when treated

Diagnosis

- See the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed, text revision¹¹

Adapted from the Australian Centre for Posttraumatic Mental Health⁶ and Forbes.¹⁰

full-spectrum PTSD,¹⁴ the condition might not be apparent initially owing to avoidance or to reluctance to discuss service-related events early in a therapeutic relationship. Comorbid physical and mental health conditions are common in PTSD and many have overlapping symptoms.

Screening. Family physicians can screen efficiently for PTSD using short instruments, such as the 4-item Primary Care PTSD Screen (**Box 1**^{6,10,11}).¹³ The instrument has a sensitivity of 78% and specificity of 87% for PTSD in patients who endorse 3 or more items.¹³ Patients who have a positive screening result should be assessed

for PTSD using diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders*.¹¹ Patients whose symptoms do not meet full diagnostic criteria for PTSD might still experience substantial functional impairment.¹⁵

Treatment

Family physicians play important roles in treating Veterans with PTSD by initiating medications to reduce symptoms, making referrals, improving functioning and quality of life, assisting with treatment compliance, monitoring progress, and facilitating psychotherapy. Although PTSD can be treated by family physicians, involving a multidisciplinary team of health professionals working within a shared care model can be very helpful, especially if the family physician does not feel adequately trained or does not have the time to provide psychotherapy. Also, PTSD in one family member can have considerable effects on the health of others, who might also need assessment and treatment.

Risk assessment. Comorbidity, suicidal or homicidal thoughts, and social support problems including dysfunctional family relationships are indicators to consider inpatient treatment or referral for psychiatric care.¹⁶ Posttraumatic stress disorder increases the possibility of suicidal thoughts,¹⁵ and comorbid depression further increases suicide risk.¹⁷ During initial PTSD assessment, male war Veterans might be angry and report violent thoughts and aggressive behaviour, including homicidal thoughts.^{18,19}

Acute stabilization. Stabilization before initiating trauma-focused psychotherapy is critical to minimizing exacerbation of pre-existing comorbid conditions such as depression and substance abuse.

Initially, stabilize patients by managing acute symptoms. Improve current functioning with psychoeducation, medication, and anxiety management training. While a firm diagnosis is being established, manage "treatable symptoms" of anxiety, depression, and insomnia, and provide supportive psychotherapy. Once the diagnosis is established, family physicians can assist in educating patients about psychiatric medication and psychotherapy, establishing treatment expectations, and introducing the importance of collaborative care with psychiatry.

For most patients, first-line treatment includes selective serotonin reuptake inhibitors, such as paroxetine and sertraline, and serotonin-norepinephrine reuptake inhibitors, such as venlafaxine,¹ which can be initiated by primary care physicians. Referral should be considered for patients with partial response at optimum doses or with difficulty tolerating first-line treatment. Next choice of medications could include a different class of antidepressant; combining 2 antidepressants of different class, such as adding mirtazapine or bupropion to a selective serotonin reuptake inhibitor or venlafaxine; or augmentation with atypical antipsychotics, such as risperidone or olanzapine, or anticonvulsants.^{1,13} Close monitoring of potential side

effects, especially in the early stages, is essential when considering augmentation or combination strategies.


Once acute symptoms stabilize, patients are more able to engage in and benefit from psychotherapy²⁰ and more likely to accept referral. Specialized psychological trauma clinics use multidisciplinary teams to manage PTSD in collaboration with family physicians. In addition, peer-support programs, like OSISS²¹ in Canada, can play a valuable role in encouraging medication and treatment compliance.²²

Definitive treatment. Although some family physicians provide psychotherapy to patients with PTSD, for physicians without specific training it might be appropriate to refer patients to therapists who have experience with military PTSD. Prolonged exposure and cognitive behavioural therapy are considered first-line treatment. In prolonged exposure, the patient reiterates the traumatic event during planned treatment sessions until the memory no longer provokes substantial anxiety. Both conditioned fear and cognitive distortions associated with PTSD are addressed during cognitive behavioural therapy. Use of eye movement desensitization and reprocessing for PTSD is supported by evidence^{1,16}; patients are instructed to imagine painful traumatic memories and associated negative cognition such as guilt and shame while visually focusing on the rapid movement of the clinician's finger.¹³

Prognosis and long-term management. There is considerable evidence that patients with PTSD continue to demonstrate improvement with pharmacotherapy up to 36 weeks of treatment. Those who discontinue medication can relapse within 6 months and, therefore, long-term treatment might be recommended.¹ It is generally recommended that patients continue medication for at least 1 year. Although remission is not always possible, with treatment patients with PTSD demonstrate substantial symptom reduction and improved quality of life. Complete remission is achieved in 30% to 50% of cases.^{1,13}

Department of National Defence, CF, and VAC

The CF provides serving personnel with a comprehensive array of services to assist with mental health issues, including a reorganized multidisciplinary primary care system, specialized Operational Trauma Stress Support Centres, and programs reducing barriers to mental health care. Canadian Forces personnel have access to general duty medical officers, medical technicians, nurses, physicians, psychologists, psychiatrists, and social workers in theatres of operation and at home in Canada.

A previous installment of Veteran Health Files described the array of programs, services, and benefits available to eligible CF and RCMP Veterans and their families experiencing effects of operational stress injuries.²³ Veterans Affairs Canada welcomes collaboration with family physicians in providing Veterans and their families with optimum physical, mental, and social health care. 

BOTTOM LINE

- Posttraumatic stress disorder (PTSD) in Veterans secondary to service-related psychological trauma can present in subtle ways.
- Two factors in the history should trigger physicians to consider PTSD: previous exposure to psychological trauma and presence of any PTSD symptoms.
- Family physicians play important roles by initiating medications to reduce symptoms, making referrals, improving functioning and quality of life, assisting with treatment compliance, monitoring progress, and facilitating psychotherapy.
- With treatment, patients with PTSD achieve substantial symptom reduction and improved quality of life; 30% to 50% achieve complete remission.

POINTS SAILLANTS

- Le trouble du stress post-traumatique (TSTP) lié à un traumatisme psychologique résultant du service militaire peut se présenter sous des formes subtiles.
- Deux facteurs présents dans l'historique du patient devraient amener le médecin à considérer la possibilité d'un TSTP : l'exposition antérieure à un traumatisme psychologique et la présence de l'un des symptômes liés à un TSTP.
- Les médecins de famille sont un maillon important dans le traitement des anciens combattants atteints du TSTP, notamment en débutant le traitement pharmacologique afin d'atténuer les symptômes, en référant vers les ressources appropriées, en améliorant le fonctionnement des individus et leur qualité de vie, en favorisant l'assiduité dans la poursuite de la thérapie, en suivant l'évolution du patient, et en facilitant la psychothérapie.
- Dûment traités, les symptômes des patients atteints du TSTP sont considérablement atténués et leur qualité de vie est nettement meilleure; une rémission complète a été observée dans 30 à 50 pour cent des cas.

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Competing interests

None declared

The opinions expressed are those of the authors and not necessarily Veterans Affairs Canada, the Department of National Defence, or the Canadian Forces.

References

1. Canadian Psychiatric Association. Clinical practice guidelines. Management of anxiety disorders. Posttraumatic stress disorder. *Can J Psychiatry* 2006;51 (Suppl 2):57-63.
2. Statistics Canada. *Canadian Community Health Survey cycle 1.2—Mental health and well-being*. Canadian Forces Supplement. Ottawa, ON: Statistics Canada; 2002.
3. Richardson JD, Elhai J, Pedlar D. Association of PTSD and depression with medical and specialist care utilization in modern peacekeeping veterans in Canada with health-related disabilities. *J Clin Psychiatry* 2006;67(8):1240-5.
4. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med* 2004;351(1):13-22.
5. Iversen AC, van Staden L, Hughes J, Browne T, Hull L, Hall J, et al. The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. *BMC Psychiatry* 2009;9:68.
6. Australian Centre for Post Traumatic Mental Health, National Health and Medical Research Council. *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder*. Melbourne, Australia: National Health and Medical Research Council; 2007.
7. Richardson JD. Military-related PTSD in Canadian veterans. *Can Psychiatry Aujourd'hui* 2009;5(1):12-3.

Resources

Resources for physicians

- Information on PTSD: www.ncptsd.org and www.ISTSS.org
- PTSD clinical practice guidelines:
 - US Department of Veterans Affairs: www.ptsd.va.gov
 - Canadian Psychiatric Association: <http://publications.cpa-apc.org/media.php?mid=446>
 - International Society for Traumatic Stress Studies: www.istss.org/treatmentguidelines/
- Senior District Medical Officer or VAC District Office: Telephone 866 522-2122 (English) or 866 522-2022 (French). If your patient is a VAC client, it is useful to provide the patient's VAC client number.
- National Centre for Operational Stress Injuries (promotes partnerships in treatment, research, and education): Telephone 866 750-0422

Resources for patients

- VAC website: www.vac-acc.gc.ca
- Peer-support website for Veterans and CF members: www.osiss.ca

8. Breslau N, Davis GC, Andreski P, Peterson E. Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Arch Gen Psychiatry* 1991;48(3):216-22.

9. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med* 2004;351(1):13-22.
10. Forbes D. Post-traumatic stress disorder best practice GP guidelines. *Aust Fam Physician* 2009;38(3):106-11.
11. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed, text revision. Washington, DC: American Psychiatric Association; 2001.
12. Jetly R, Cooper K. PTSD: the symptoms and how to treat. *Can J Contin Med Educ* 2008;20(2):43-6.
13. Friedman MJ. Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *Am J Psychiatry* 2006;163(4):586-93.
14. Staab JP. *Posttraumatic stress disorder*. Philadelphia, PA: Physicians' Information and Education Resource, American College of Physicians; 2010.
15. Marshall RD, Olsson M, Hellman F, Blanco C, Guardino M, Struening EL. Comorbidity, impairment, and suicidality in subthreshold PTSD. *Am J Psychiatry* 2001;158(9):1467-73.
16. Ursano RJ, Bell C, Eth S, Friedman M, Norwood A, Pfefferbaum B, et al. Practice guidelines for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *Am J Psychiatry* 2004;161(11 Suppl):3-31.
17. Kaufman J, Charney D. Comorbidity of mood and anxiety disorders. *Depress Anxiety* 2000;12(Suppl 1):69-76.
18. Forbes D, Creamer M, Hawthorne G, Allen N, McHugh T. Comorbidity as a predictor of symptom change after treatment in combat-related posttraumatic stress disorder. *J Nerv Ment Dis* 2003;191(2):93-9.
19. Forbes D, Hawthorne G, Elliott P, McHugh T, Biddle D, Creamer M, et al. A concise measure of

- anger in combat-related posttraumatic stress disorder. *J Trauma Stress* 2004;17(3):249-56.
20. Davidson JRT, Van Der Kolk BA. The psychopharmacological treatment of posttraumatic stress disorder. In: Van Der Kolk BA, McFarland AC, Weisaeth L, editors. *Traumatic stress: the effects of overwhelming experience on mind, body and society*. New York, NY: The Guilford Press; 1996. p. 510-24.
21. Operational Stress Injury Social Support program [website]. Ottawa, ON: Department of National Defence, Canadian Forces; 2006.
22. Richardson JD, Darte K, Grenier S, English A, Sharpe J. Operational Stress Injury Social Support: a Canadian innovation in professional peer support. *Can Mil J* 2008;9:57-64.
23. Shields M, White M, Egan M. Battlefield blues. Ambivalence about treatment among military Veterans with depression. *Can Fam Physician* 2009;55:799-802 (Fr), CFPPlus (Eng). Available from: www.cfp.ca/cgi/content/full/55/8/799/DC1. Accessed 2010 Mar 23.

Veteran Health Files is a quarterly series in *Canadian Family Physician* coordinated by Veterans Affairs Canada. The series explores situations experienced by family physicians caring for Veterans of military service. For further information on this series, contact **Dr Jim Thompson**, Veterans Affairs Canada Head Office, Charlottetown, PEI; e-mail research-recherche@vac-acc.gc.ca