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### References

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### Quick Lesson

#### **Military Personnel and Veterans, Post-Traumatic Stress Disorder**

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#### **Description/Etiology**

Post-traumatic stress disorder (PTSD) was first identified during World War I and was initially referred to as shell shock. The American Psychiatric Association officially recognized PTSD as a type of anxiety disorder in 1980, ushering in a change in ideology that viewed PTSD symptoms as a result of a trauma rather than as an internal weakness or inability to cope. Individuals' cognitive and emotional processes were seen as determining who was able to recover from trauma and who would develop symptoms of the disorder. Although traumatic events can take many forms (e.g., natural disasters, severe injury, abuse, brushes with death), some events, such as rape, torture, and combat-related stress, are more likely to be experienced as traumatic.

Today, PTSD has been reclassified as a trauma and stressors-related disorder; it is the most common psychiatric disorder experienced by military personnel. Symptoms may wax and wane over time, which can affect how the disorder manifests in clients. Immediately after the trauma, symptoms may not be present but may develop later and worsen over time. Symptoms may also come and go in response to various triggers. According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, social workers should use the following criteria when assessing a client for a diagnosis of PTSD:

Criterion A: Stressor--experiencing, witnessing, or being confronted with a trauma or life-

threatening event

Criterion B: Intrusion symptoms--persistent re-experiencing of the event in the form of thoughts, flashbacks, nightmares, illusions, or hallucinations

Criterion C: Avoidance--avoidance of stimuli associated with the traumatic event (e.g., avoidance of thoughts, avoidance of people or places, detachment, inability to recall details of the events)

Criterion D: Negative alterations in cognition and moods—thoughts and moods worsen (e.g., persistent negative beliefs, feelings of alienation, constricted affect, diminished interest in activities)

Criterion E: Arousal—alterations in arousal and reactivity (e.g., irritability, aggressive behavior, hypervigilance, intense anxiety, difficulty concentrating)

Criterion F: Duration—persistence of symptoms for more than one month

Criterion G: Functional significance—significant distress or functional impairment

Criterion H: Exclusion—disturbance not due to medication, substance abuse, or illness

Men and women who serve in the military are at the highest risk for PTSD, as they are more likely to be exposed to trauma and to experience more severe trauma than persons not in the military. Sources of trauma for military personnel include combat trauma, sexual trauma (e.g., sexual harassment, sexual assault), witnessing or participating in death and injury, and living in extreme conditions (e.g., exposure to heat, radiation, infectious disease, unsanitary conditions).

Effective treatment of PTSD in military personnel entails helping clients recognize the fear-related memories, incorporate new meanings for those memories, and develop stress-management skills and coping mechanisms. Standard methods of intervention include cognitive behavioral therapy (CBT), group therapy, and eye movement desensitization and reprocessing (EMDR). EMDR involves the use of imagery and rapid eye movement to desensitize the client through prolonged exposure to stimuli. Severe symptoms can be stabilized and managed with medications. Clients should be assessed to determine if they may benefit from pharmacological therapy: beta blockers, antidepressants, and mood stabilizers can help with panic attacks, sleep disruption, and severe symptoms of hyperarousal.

## **Facts and Figures**

The lifetime prevalence rate of PTSD among Americans who have not served in the military is 7.8% (Chaumba & Bride, 2010). From 2004 to 2012, the percentage of active-duty military personnel in whom PTSD was diagnosed rose from 1% to 5% (Institute of Medicine, 2014). In 2012, 13.5% of members of the Army, 10% of members of the Marine Corps, 4% of members of the Navy, and 4% of members of the Air Force had PTSD at some point during the year (Institute of Medicine, 2014). In that same year, approximately half a million veterans from all eras sought treatment through the Veterans Health Administration (VA) for PTSD (Institute of Medicine, 2014). The increase in PTSD diagnoses in U.S. military personnel is attributed to an increase in the number and length of deployments, the difficulty in modern conflicts in distinguishing enemy combatants from civilians, and an increased likelihood of surviving combat wounds and injuries. Recent studies show that U.S. military personnel involved in Operation Iraqi Freedom also report experiencing trauma “related to loss (e.g., knowing someone seriously injured or killed), moral conflict (e.g., being responsible for the death of a noncombatant), horror (e.g., handling or uncovering human remains), or helplessness (e.g., seeing ill or injured women or children whom they were unable to help)” (Hoge et al., 2004). Combat and sexual assault are the most commonly

reported traumas among military personnel. Although about half (40–50%) of men in the military are exposed to direct combat trauma, almost two thirds(65.4%) of women in the military are exposed to trauma during their work in supporting roles of caring for wounded, dying, and deceased combatants (Hoge et al., 2004). Military sexual trauma is another factor in PTSD for military personnel and veterans. In 2012, 6.1% of active-duty women reported experiencing unwanted sexual contact, up from 4.4% % in 2010;in the same period, the percentage of active-duty men reporting unwanted sexual contact remained the same, 1.2% (Department of Defense, 2012). In 2012 the VA spent \$3 billion and the Department of Defense \$294 million on treatment of PTSD in military personnel (Institute of Medicine, 2014).

## **Risk Factors**

A 2006 U.S. Army Mental Health Advisory Team report found that “multiple deployments are increasing... and that soldiers who were deployed to Iraq more than once were more likely to screen positive for PTSD.”(Mental Health Advisory Team, 2006)Factors that may increase the risk that a service member will develop chronic PTSD include exposure to trauma as a result of combat, personal injury, involvement in atrocities, and perceived threat to life. Military personnel of non-White race, lower socioeconomic status, lower intelligence, younger age, or who have a history of familial discord, behavioral problems in childhood, or pre-trauma psychopathology are also at increased risk for PTSD. Active-duty personnel and veterans who have experienced a traumatic event are more likely to develop PTSD if they have a low level of social support, negative homecoming experiences, and poor coping skills. Military personnel who previously were victims of violence (e.g., terror attacks, childhood abuse, sexual assault, criminal acts) are also at increased risk.

## **Signs and Symptoms/Clinical Presentation**

Psychological: negative thoughts and perceptions; hallucinations, delusions, nightmares, flashbacks, suicidal ideation, and exaggerated reactions to stimuli; symptoms of depression and anxiety; memory loss, especially regarding details of the trauma; trouble concentrating; poor impulse control; feelings of guilt or fear

Behavioral: issues with substance use; perpetration of intimate partner violence; sexual dysfunction; marital discord; dissociation demonstrated by attempting to avoid places, persons, thoughts, conversations, or activities associated with the traumatic event; agitation;intense anger; feelings of numbness

Physical: dishevelment, poor personal hygiene; somatic complaints, including gastrointestinal disturbances, muscle aches, headaches

Social: withdrawal; self-isolation; limited friendships; poor social support; reduced emotional intimacy; trouble performing daily tasks (e.g., cleaning, grooming, cooking); impaired ability to work and reintegrate into society

## **Social Work Assessment**

### **Client History**

Ask about client’s experience during deployment; note physical findings, overall presentation, and level of functioning; assess for history of substance abuse, psychiatric history, childhood abuse, and any exposure to violence; determine number, location, and length of deployments

Conduct a biopsychosocialspiritual assessment to include information on physical, mental,

environmental, social, financial, and medical factors as they relate to client's treatment  
Assess client's stress-management skills and coping mechanisms as well as the support systems currently available to the client

Ask client for permission to interview family members and/or collateral sources

### **Relevant Diagnostic Assessments and Screening Tools**

The Posttraumatic Stress Disorder Checklist–Military Version (PCL-M) is a self-report tool specifically designed for use with military personnel. It is a 17-item checklist that can be used to assess severity of symptoms and to diagnose PTSD

The PTSD Screening and Diagnostic Scale (PSDS) is a 38-item self-report inventory that uses the six *DSM-IV-TR* criteria for PTSD to assist in making a diagnosis

The Impact of Events Scale - Revised (IES-R) can help measure a client's subjective response to traumatic stress using 22 questions that assess three subscales of symptoms: hyperarousal, intrusion, and avoidance

### **Laboratory Tests of Interest to the Social Worker**

Because of the high rate of substance use among persons with PTSD, it may be appropriate for clients to undergo drug testing

### **Social Work Treatment Summary**

Treatment of PTSD utilizes active discussion and exploration of traumatic experiences with trauma-focused interventions such as CBT and EMDR, a specific CBT technique. CBT helps the client identify irrational beliefs and replace them with more adaptive thought processes. This method has evolved to include education on stress response, breathing training, and the mental recounting of the event to decrease emotional response. CBT currently is considered the standard of care for PTSD by the U.S. Department of Defense. In 2004 the U.S. Department of Veterans Affairs and the Department of Defense concluded that EMDR is an attractive treatment method because clients have shown significant clinical improvements in just a few sessions and EMDR may be better tolerated by clients who are resistant to recounting traumatic events (Russell, 2008). Clients should be referred for a psychiatric evaluation in order to determine if they may benefit from pharmacological treatment with beta blockers (e.g., propranolol), SSRIs (e.g., sertraline, fluoxetine), antianxiety agents (e.g., benzodiazepines), or antipsychotics (e.g., risperidone).

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

<b>Problem</b>	<b>Goal</b>	<b>Intervention</b>
Client is experiencing symptoms that are common with PTSD	Determine if criteria for diagnosis are met	Conduct a complete biopsychosocial-spiritual assessment; document client's experiences during deployment; utilize assessment tools (PCL-M or PSDS)
Client meets criteria for acute or chronic PTSD, including hyperarousal to stimuli and mood symptoms	Decrease response to stimuli and stabilize mood	Develop a treatment plan utilizing trauma-focused interventions such as CBT and EMDR; determine whether client could benefit from individual and/or group therapy; refer for psychiatric evaluation if needed

Client may be exposed to future trauma/stressors	Develop stress-management skills and a relapse prevention plan	Use strengths-focused approach to teach stress reduction, relaxation, and breathing techniques to assist client in reducing his or her reaction to stimuli; link client to resources and support groups as part of relapse prevention
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## Applicable Laws and Regulations

A “limits to confidentiality” document needs to be acknowledged and signed by the client prior to beginning treatment. Social workers are required to explain the limits to confidentiality and the client’s rights; this reinforces trust and gives the social worker flexibility and discretion to maintain confidentiality (Yarvis, 2011)

Social workers need to be aware of military regulations regarding confidentiality when providing mental health services to active-duty personnel and recognize that these limits may be a barrier for clients to disclosure of traumatic events. Before 1999, there was no client-therapist confidentiality protection in the military setting. President Clinton issued an executive order in 1999 that established a military rule regarding privilege between therapists and clients in the military. Military Rules of Evidence, Rule 513 (MRE 513), does not protect the client’s rights as strongly as federal laws for civilians do, however. If the social worker is court-ordered to reveal a client’s information, he or she may ask the judge to include a protective order to admit only portions of the records, not the records in their entirety, and to seal the record of the hearing in order to safeguard the client’s privacy. Under MRE 513, the exceptions to confidentiality include:

If the client is deceased

If there is evidence of spousal abuse or child abuse

If there is mandatory reporting under federal, state, and military law

If the client presents as a danger to him- or herself or to others

If the client is trying to commit fraud

If there is a constitutional requirement (i.e., the accused’s right to due process may be weighed against the accuser’s right to privacy)

To ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission

This military mission inclusion is considered a grey area: it gives the military great leeway in requesting records

Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly

## Available Services and Resources

U.S. Department of Veterans Affairs National Center for PTSD, <http://www.ptsd.va.gov>

National Institute of Mental Health, <http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>

## Food for Thought

Stigma is reported by both active-duty personnel and veterans as a major barrier to seeking mental health treatment. This stigma is based on the beliefs that seeking help or acknowledging

the existence of a mental health condition will result in an unfavorable reaction from peers or commanders; have a negative impact on selection for missions or promotion in rank; or otherwise undermine the individual's military career

Military personnel with PTSD may have difficulty reintegrating into civilian life

It is important for social workers to understand the language and structure of the military as well as service members' commitment to mission, honor, and sacrifice

Neither the VA nor the Department of Defense has a system in place to collect, analyze, assess, or disseminate any data on quality of PTSD care, even though both provide extensive PTSD treatment services. This has been highlighted by the government and the public as an area that is in need of improvement (Institute of Medicine, 2014)

### Red Flags

It is typical for veterans to attend one or two sessions of treatment and not return; therefore, social workers and clinicians must take necessary steps to ensure a client's regular attendance and active engagement in the treatment process

Explosive behaviors are more common among those whose traumas were experienced during military service

Times of transition within the military setting (e.g., beginning a deployment, returning from deployment, exiting active duty) may cause stress which in turn may trigger PTSD; clients may need to be encouraged to access transition coaching, which is available to veterans and active-duty service members through the VA system (Defraia et al., 2014)

### Discharge Planning

Help client to locate a support group and encourage weekly attendance

Provide client with hotline information and emergency contacts to use during times of crisis

Educate client's family members on the risk factors and signs of PTSD so they are equipped to lend support and seek help

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### **Reviewer(s)**

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