PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

Australian Guidelines for the Treatment of
Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types
Military and ex-military personnel and PTSD

This *Military and ex-military personnel and PTSD* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with military and ex-military personnel. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*: www.phoenixaustralia.org/resources/ptsd-guidelines/.

Background issues

Military personnel are confronted with a range of experiences that may contribute to posttraumatic stress disorder (PTSD), including both military-specific events and traumas that also affect the general population. Research with the Australian Defence Force (ADF) suggests that the most common traumatic event experienced by serving members is seeing someone badly injured or killed, or unexpectedly seeing a dead body. In terms of developing PTSD, experiences such as witnessing atrocities and accidentally injuring or killing another person, in addition to other interpersonal traumas such as rape, domestic violence, being stalked, and being kidnapped or held captive, pose the most significant risk.[1]

During deployment, it is not uncommon for military personnel to experience multiple traumatic events. Military deployment frequently involves exposure to real or threatened death and serious physical injury that can lead to PTSD. Furthermore, the nature of traumatic events experienced on deployment can challenge fundamental beliefs about the self, the world, and humanity. For example, traumatic events may involve the death of civilians and destruction of communities on a scale that is often unimaginable and for which the person has had little preparation. Military personnel themselves may have committed acts of violence that, with the benefit of hindsight or emotional distance from the event, may be deemed to be atrocities – such experiences may shatter previously held beliefs about the self.

Increasingly, as the armed services are involved in humanitarian and peacekeeping duties, military personnel can be exposed to situations of considerable human suffering without any immediate threat to themselves. It was initially thought that peacekeepers had low rates of exposure to traumatic stressors. Several recent studies, however, have indicated that peacekeeping missions may present a range of unique stressors that can have a significant psychological impact on deployed personnel.[2] For example, in one study, peacekeepers reported negative deployment experiences including knowing that many of the war criminals were not arrested, seeing children who were the victims of war, seeing civilians in despair, seeing the physical devastation of the country's infrastructure and environment, and knowing that there was a lack of supplies for civilians.[3] In addition, peacekeepers often experience frustrations associated with peacekeeping duties, such as restrictive rules of engagement.[4]

An understanding of the psychological underpinnings of the serving member or veteran's initial presentation and a preparedness to give sufficient time to establish a trusting relationship will be immeasurably helpful. Given the war-related nature of traumatic events experienced by many military and ex-military personnel, they may anticipate

negative evaluation on the part of the clinician. To work effectively with military personnel, the clinician must demonstrate a willingness to listen and the capacity to tolerate the details of traumatic experiences whilst maintaining a positive regard for the individual throughout.

Finally, there is some evidence to suggest that military recruits have increased rates of childhood physical abuse, sexual abuse and neglect, as well as high rates of family dysfunction compared with community averages, and that these factors are particularly salient in the development of PTSD in this population.[5, 6] The practitioner needs to be aware of any such pre-military history, as it is likely to influence the establishment of a therapeutic relationship as well as treatment planning.

Presentation

Research in the US, conducted across a range of conflicts, indicates that PTSD affects between two and 17 per cent of veterans at any given time.[7] Australian data is limited, however the available evidence suggests that the figures published by Richardson and her colleagues are relevant in the Australian context. For example, the point prevalence of PTSD is estimated to be around 12 per cent in Vietnam veterans, five per cent in Gulf war veterans, and eight per cent in current serving members of the ADF.[1, 8, 9] The presentation of symptoms for this group tends to be somewhat different to other traumatic stress victims. The association between the trauma exposures and the workplace means PTSD often has an indirect presentation in these cases. For example, the individual's difficulties may manifest as increasing conflict with senior personnel over a variety of operational and disciplinary issues. Furthermore, the individual may have had a prolonged period of symptomatic distress that they have attempted to minimise and deny. The general sense of camaraderie and collegial support in the military often assists the individual in maintaining a facade of functioning. A failed promotion or a disciplinary charge may be a consequence of the individual's increasingly disorganised behaviour, and often becomes the focal point around which an individual's distress is manifest. The indirect manifestation of the individual's distress can delay appropriate assessment and diagnosis.

The clinical manifestation of an individual's distress in these situations can occur in a variety of ways. For example:

- The individual may initially present with a prolonged period of numbing and increasing interpersonal insensitivity. This can manifest as inappropriate management of junior personnel or conflict with superiors.
- Interpersonal conflict with family and, in particular, violent outbursts, is another indirect manifestation that may first be brought to the attention of welfare services from a secondary victim, such as the spouse.
- Comorbid alcohol abuse is not an uncommon presentation where the individual attempts to self-medicate. The associated interpersonal and work-related difficulties may lead to others in the person's social or work networks being aware of the difficulties prior to the individual themselves.
- Physical complaints may be the primary presenting problem. Veterans with PTSD tend to have more physical symptoms and higher symptom severity than veterans without PTSD.[10] It may be that given the stigma surrounding mental health problems, expressing distress in the form of somatic symptoms is perceived to be more acceptable than showing signs of PTSD.
- An intense pattern of distress may emerge in response to a recent traumatic event, even one of apparently minor severity. The recent event, however, may have some particular similarity to a prior exposure – perhaps a more severe event that played an important role in the initial disruption of the individual's reactivity to stress. Hence, the longitudinal pattern of symptoms needs to be assessed, as well as the acute disorganisation in response to recent exposures.
- Individuals who leave the military may first present some time after their discharge. The loss of identity and support through the structure of the organisation that has provided the raison d'etre for the individual's functioning can lead to the progressive emergence of PTSD symptoms, including increasing and distressing recollections and nightmares.

Assessment

Systematic screening has an important role in identifying PTSD in military personnel who are either engaged in repeated high-risk exposures or who have had a recent deployment or major event which carries a significant risk of PTSD.[11] Recent research suggests that it may also play a valuable role at pre-deployment.[12] However, it should be recognised that the emergence of symptoms might be delayed, pointing to the value of an annual health assessment above and beyond an initial screening process. The administration of screening questionnaires should only be seen as a guide to a more systematic diagnostic assessment by a trained clinician for anyone who screens as being at risk.

A range of psychometric instruments have been trialled in military services for monitoring the emergence of symptoms. Given the issues about under reporting, there may be some value in using lower thresholds to determine

referral for a clinical assessment. Any screening process should also regularly interview a fixed proportion of people who are symptomatic to remove the stigma of referral for follow-up. Measures of trauma exposure and mental health symptoms need to be flexibly applied in regards to the nature of the exposure. The Posttraumatic Checklist (PCL; Weathers, Litz et al. 1993[13]) has a military version which addresses this challenge because it does not simply focus on exposure to a sole traumatic event but, rather, talks more generally about 'military experiences'. A cut-off of 50 on the PCL has been established as indicative of a diagnosis of PTSD in ex-serving military veterans presenting for treatment in clinical settings and has been validated for Australian veterans.[14] At a population level, across the Australian Defence Force, an indicative cut-off for a diagnosis of PTSD was 53.[1] Based on Australian and US research, a cut-off of 30 is used in the Australian Defence Force to signal the requirement for referral to a psychologist to minimise the potential for someone with PTSD to be missed. A brief version of the PCL for use as a screening measure in military populations has also been developed.[15]

Individuals with a work-related disability are often placed in a difficult conflict about seeking assistance because this can lead to significant discrimination and disadvantage in the workplace. This is a recognised difficulty when presenting to occupational health services and has particular relevance for military populations, where an adverse health assessment may make the person unsuitable for deployment. The potential stigma of mental health problems as a sign of weakness in the 'warrior culture' of the military can also be an important barrier to care. This situation requires a high level of skill from the assessing clinician. It is important that supervisors who are familiar with the individual's normal disposition and capability have some awareness of the indirect manifestation of the effects of PTSD in the workplace so that appropriate referrals can occur. The health professional needs to have access to personnel records (which may, for example, highlight absences or disciplinary measures for aggression or substance abuse) to assist in a clinical assessment.

The clinical presentation of military personnel and veterans infrequently occurs following the initial exposure to a single traumatic incident. The more typical scenario is where the individual breaks down after repeated experiences of a variety of traumatic incidents which entail varying degrees of a sense of personal threat, often combined with the witnessing of harm or death to others. The extent to which a specific incident is personalised through some identification with the event or the victim plays an important role in modifying the resilience and vulnerability of the individual. Military deployments that involve close personal contact with civilians (or even enemy personnel) carry a particular risk.

The available evidence suggests that prolonged exposure or repeated intense exposures over a period of time lead to an accumulated risk (see, for example, Smid et al.[16]). While there appears to be some relationship between multiple deployments and level of symptomatology, the intensity of trauma or combat exposure appears to be more important than the actual number of deployments in predicting mental health outcomes.[1] As a consequence, the recommendation regarding comprehensive assessment of the individual's trauma history applies; the history obtained from military personnel should focus on the lifetime exposure, as well as the immediate antecedent event that may have prompted the presentation for treatment.

Treatment

A significant body of research has been conducted with this population, supporting the relevance and applicability of standard treatment recommendations for PTSD.

The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. **Grade B**
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**
- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**
- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**

- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

The particular challenge with veteran and military populations is to implement treatment as early as possible. Using the principles of secondary prevention, this minimises the development of a series of secondary patterns of adaptation that in themselves can present a significant disadvantage. The systems of care that ensure early identification, such as screening and addressing stigmatisation in the workplace are of particular importance. Recognition of the value to a defence force of maintaining the skill base of highly trained personnel is an important priority in encouraging a general attitudinal change within these organisations. Significant experience in dealing with veteran and military populations is also an important matter for clinicians, because understanding the specific culture of military organisations can be central to the development of a positive therapeutic relationship with the person with PTSD.

A number of clinical treatment trials with veteran populations, both pharmacological and psychological, have found treatment to be less effective than for non-veterans with PTSD. However, this is not a consistent finding, with the only randomised controlled trial (RCT) of psychological treatment for Australian veterans with PTSD indicating cognitive processing therapy (CPT) to be highly effective in this population.[17] More modest outcomes in a number of these studies may be due to characteristics of the veterans themselves (male gender, nature and duration of traumatic experiences, chronicity of PTSD, high rate of comorbidity), the less rigorous treatment interventions generally used with this population, or potentially complicating factors relating to veterans' compensation, pensions, and other entitlements. All these factors are often associated with more modest responses to treatment. Specific consideration of the following points may be helpful:

- Treatment planning needs to take into consideration the multiplicity of traumatic exposures that military personnel have had to deal with and the consequent multiple 'triggers' or trauma reminders.
- Many symptoms of PTSD, including hypervigilance, exaggerated startle response, anger, and emotional numbing, can be adaptive and even life-saving in combat situations. Addressing these issues can be of particular relevance to those individuals who have had a prolonged period of service where these responses may have become ingrained.
- The existence of comorbid substance abuse is a frequent therapeutic challenge. This should be dealt with alongside the initial control of an individual's symptomatic distress. This approach takes account of the fact that frequent substance abuse has often been a form of self-medication that the individual has used to address their difficulties. Integrated treatment of both PTSD and substance abuse should be considered with the proviso that the trauma-focussed component of PTSD treatment does not commence until the person demonstrates the capacity to manage distress without recourse to substance abuse. Information on PTSD and strategies to deal with PTSD symptoms should be provided, as PTSD symptoms may worsen during substance abuse treatment due to acute withdrawal or loss of substance use as a coping mechanism.
- Due to the nature of veterans' compensation systems, some people may perceive a vested interest in maintaining symptomatology until all proceedings associated with their claim have been completed. Therapists are advised to address this issue with the person before initiating treatment. An open discussion of the pros and cons of maintaining symptomatology can often be useful.

A particular challenge when working with currently serving military personnel is the management of exposure to further stressors in the workplace during the immediate aftermath of treatment. In general, it is important to remove the external threat and triggers to the individual's distress. A model of sensitisation and kindling (whereby repeated experiences of traumatic incidents result in increased responsivity and progressively more severe reactions over time) is a valuable theoretical construct to inform any cognitive behavioural management.

Although no empirical evidence exists, it is reasonable to assume that the challenge of determining recommendations for future duties – and particularly fitness to deploy following treatment for PTSD – should be based on an individual's residual pattern of arousability, degree of recovery, and general adaptation. If a significant degree of triggered distress remains, it is probable that further exposures will exacerbate the individual's symptoms. In these instances, it is best to minimise the probability of such exposures and recommend alternative duties. Other factors to consider might include current circumstances (especially support networks within and outside the military), duration and severity of the most recent episode, and prior risk factors (such as adverse childhood, other traumatic exposures, prior psychiatric history). A key additional issue will be the person's wishes – do they want to redeploy? It is reasonable to assume that relapse will be more likely if the person does not want to be redeployed.

Recommended reading

Kearnery, G. E., Creamer, M., Marshall, R., & Goyne, A. (2003). *Military stress and performance: The Australian Defence Force experience*. Melbourne: Melbourne University Press.

Moore, B. A., Penk, W. E., & Friedman, M. (2011). *Treating PTSD in military personnel: A clinical handbook*. New York: Guildford Press.

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This information was taken from the Military and Ex-Military Personnel section (p.146-148) of the Special Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Military and Ex-Military Personnel section was developed by Phoenix Australia in collaboration with Professor Mark Creamer, Clinical Psychologist, Department of Psychiatry, University of Melbourne; Professor Alexander McFarlane, Director, Centre for Traumatic Stress Studies, University of Adelaide; and Dr Duncan Wallace, Psychiatrist, Australian Defence Force Centre for Mental Health.

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