



# SAPA JOURNAL



## The Society of Army Physician Assistants

P O Box 07490, Fort Myers, FL 33919 Phone & Fax (239) 482-2162

Vol. 18, NO. 4    A Civilian Organization Representing Army PAs    Jul/Aug 2006

### SAPA BOARD OF DIRECTORS AT WORK



L-R: Donald Black, Paul Lowe, Casey Bond, Steve Ward, Frank Piper, Back of Jim Miller's head

Minutes of the Board of Directors Meeting  
Tuesday, 25 April 2006

Meeting was called to order at 10:10 a.m.

- DIRECTORS PRESENT:**    President: Steve Ward  
 President Elect and Director of Reserves: Frank Piper  
 Immediate Past President: Casey Bond  
 Treasurer: Jim Miller  
 Director of National Guard: Don Black
- DIRECTORS ABSENT:**
- Executive Director: Hal Slusher (Excused)  
 Secretary: Sherry Morrey (Excused)  
 Director of Active Duty: Sherry Womack
- COMMITTEE CHAIRS:**
- Conference Registrar: Bob Potter  
 Conference Committee: Pat Malone

#### REPORTS:

1. **Past President:** Casey stated he would be taking minutes of the meeting since the Secretary was called away due to an emergency. Otherwise he had no official report at this time.

2. **President:** Steve had no official report at this time.

3. **President-Elect:** Frank had no official report at this time.

4. **Secretary:** Casey requested that the BOD review the minutes of the 27 April 2005 BOD meeting. An error was noted in item 3 of new business which stated that Steve self-declared for the position of President-Elect. This was amended to reflect that Frank had self-declared for the Position of President-Elect. Paul moved that the minutes be accepted as amended. Frank seconded the motion and the motion carried. A roster of the BOD email addresses and phone numbers was distributed and updated (Enclosure 1).

5. **Treasurer:** Jim mentioned that last year we started accepting credit card transactions for membership and the results exceeded expectations. Jim noted that there continues to be a problem with returned checks. This was discussed by the BOD and it was agreed that returned checks would be returned and the checks would be reported as mail and credit fraud. Jim mentioned that he would soon be ordering new checks and asked if he should change the address on the checks from the old 6762 Candlewood Drive to the new P.O.Box 07490. All agreed that the new P.O. Box address should be used. Jim asked if historic treasury records should be converted to an electronic version for storage purposes or if hard copies should be maintained. It was decided to maintain hard copies until we reviewed our by-laws and policies and procedures. Jim presented his report entitled "Current Financial Status of SAPA" dated 27 April 2006 (Enclosure 2). The estimated balance in the Armed Forces Bank is \$280,286.55 and in the First Citizens Bank \$13,873.02 for a total banking deposits of \$294,159.57. Jim noted the increase in bank assets between 2005 and 2006 is \$12,147.77. Jim also noted he would need 3 members to serve as auditors to review his records prior to adjournment

## SAPA OFFICERS

### SOCIETY OF ARMY PHYSICIAN ASSISTANTS

P O Box 07490, FT. MYERS, FL 33919-6402

Phone and Fax - 239-482-2162

**Executive Director: Harold E. Slusher, PA-C**

Address and phone as above, e-mail - hal.slusher@juno.com

SAPA Web Page: <http://www.sapa.org> (Webmaster: Mike Roberts)

#### PRESIDENT

**LTC Frank Piper, Jr., SP, PA-C**

e-mail - [Fchiefs@sbcglobal.net](mailto:Fchiefs@sbcglobal.net)

#### PRESIDENT ELECT

**Paul W. Lowe, PA-C**

e-mail - [lowepw@earthlink.net](mailto:lowepw@earthlink.net)

#### IMMEDIATE PAST PRESIDENT

**Steven W. Ward, PA-C**

e-mail [swardpac@ctvea.net](mailto:swardpac@ctvea.net)

#### SECRETARY

**Casey Bond, PA-C**

e-mail [caseybond@earthlink.net](mailto:caseybond@earthlink.net)

#### TREASURER

**James L.C. Miller, PA-C**

e-mail - [jmillx2@earthlink.net](mailto:jmillx2@earthlink.net)

#### DIRECTOR, ACTIVE DUTY ARMY PAs

**MAJ Sherry L. Womack, SP, PA-C**

e-mail - [sherry.lynn.womack@us.army.mil](mailto:sherry.lynn.womack@us.army.mil)

#### DIRECTOR, US ARMY NATIONAL GUARD PAs

**LTC Michael LaBelle**

[michael.labelle@us.army.mil](mailto:michael.labelle@us.army.mil)

#### DIRECTOR, US ARMY RESERVE PAs

**CPT Richard Tea**

[richard.tea@us.army.mil](mailto:richard.tea@us.army.mil)

#### MEMBERSHIP DIRECTOR

**Paul W. Lowe, PA-C**

e-mail - [lowepw@earthlink.net](mailto:lowepw@earthlink.net)

### SAPA CONFERENCE STAFF

#### CONFERENCE COORDINATOR: Patrick E. Malone, PA-C

1413 Blairwood Drive

Fayetteville, NC 28304

e-mail - [sapamed@aol.com](mailto:sapamed@aol.com)

#### CONFERENCE REGISTRAR: Bob Potter, PA-C

PO Box 623

2Monmouth, IL 61462

SAPA Voice Line: 309-734-5446

Fax: 309-734-4489

e-mail - [orpotter@aol.com](mailto:orpotter@aol.com)

#### CO-COORDINATOR: David M. Paulson, PA-C

**CO-REGISTRAR: Judy Potter**

**DECORUM AND MORALE: Nicole Potter**

**SALES AND MARKETING: Steve Ward, PA-C, Bob Egbert, PA-C,**

**Tom Matherly, PA-C,**

**MODERATORS/AUDIO-VISUAL: MAJ Irwin Fish, PA-C**

## SAPA JOURNAL STAFF

Editor: Casey Bond, PA-C

## COMMITTEES

### SCHOLARSHIPS/AWARDS

**LTC-R Donald Parsons, PA-C (Chair)**

**MAJ-R Jerald Wells, PA-C**

### SAPA HISTORIAN

**William Long, PA-C**

### MINORITY AFFAIRS

**MAJ-R Jerald Wells, PA-C**

### PUBLIC EDUCATION

**Harold E. Slusher, PA-C**

### PROFESSIONAL WELLNESS

**Michael Champion, PA-C**

### LEGISLATIVE AFFAIRS

**Harold E. Slusher, PA-C**

### DELEGATES TO AAPA HOUSE OF DELEGATES

**Steve Ward, PA-C (Chief Delegate)**

**Frank Piper, PA-C**

### ACADEMY LIASON

**COL Sherry Morrey, SP, PA-C**

### COMMUNICATIONS/ELECTRONICS

**Steven Ward, PA-C**

**Irvin Fish, PA-C**

**Bob Potter, PA-C**

The SAPA Journal staff and SAPA Board of Directors encourages membership participation in this publication. Feel free to use this forum to present your views on any topic you desire. The publication of clinical articles on any subject is also solicited, however, to reduce our workload, we do request articles be presented typed, double-spaced format, and on CD, Microsoft Word format. The editor reserves the right of final acceptance of articles as well as the right to serialize articles which are too lengthy to be included in a single issue.

The SAPA Journal is the official publication of the Society of Army Physician Assistants. The views and opinions expressed herein are not necessarily those of the editors, SAPA, the SAPA Board of Directors or the Department of the Army unless explicitly expressed as such

**This is not an official Army Publication.**

of the conference and he asked the BOD to assist in recruiting these members. Don moved that the Treasurer's Report be approved. Paul seconded the motion and the motion carried.

6. **Executive Director:** Since the Executive Director was absent but expected to arrive later in the week, Casey mentioned that the BOD consider an ad-hoc meeting when the Executive Director arrived.

7. **Conference Committee:** Pat thanked the BOD, and especially Bob, Dave, and Hal for their hard work over the past year in preparation for the conference. Pat stated that so far everything seemed to be running smooth and that the hotel staff continued to be very accommodative. Pat stated he had some requests to keep the coffee in the break area out longer and he was going to address this with the hotel staff. Bob mentioned that one of the hotel staff suggested the cost saving measure of insuring accurate head count to the Exhibitor Appreciation Luncheon by issuing tickets. Pat stated that the President's Reception was a resounding success. Pat stated that he was investigating the possibility of having a "Spouse Day to the Beach" next year. He would get back to the BOD with the details.

8. **Director of Active Duty:** Sherry was absent.

Frank stated that Bill Tozier informed him that there are presently 672 active duty army PAs and that the end strength for active duty PAs was growing and up 37% in the last 2 years. It was also noted that the Interservice PA Program (IPAP) had approximately 500 applications for 95 army positions.

9. **Director of Reserves:** Frank said he has had discussions with COL Tozier regarding the difficulty determining precisely how many Reserve PAs there are since they are assigned to so many different types of units and there is not a common data base to capture those numbers. Frank stated that 62 PAs from Troop Program Units (TPUs) had been deployed.

10. **Director of National Guard:** Don estimated that 32% of all National Guard PAs have been deployed. He expressed concern about insuring adequate train-up time for these individuals prior to their deployment.

11. **Membership Director:** Paul reported a total of 818 members, of which 234 are Fellow members; being also AAPA members (Enclosure 3). Approximately 197 members failed to renew their membership after three mailed and three e-mailed renewal notices and were dropped from the membership rolls. 104 have since renewed from the former member data base. Steve asked if there was a mechanism for determining if deceased PAs were members of SAPA, as well as a mechanism to notify Tom Matherly in order to have their name placed on the Memorial Plaque. Paul stated he could determine membership status from his data base and, if

confirmed, e-mail Tom to have the name placed on the plaque. The prerequisites for Life Membership were discussed. The BOD was in general agreement that the prerequisites were Scully Award recipients, or Hall of Fame inductees, or those who have served a successful term as President, or at the discretion of the BOD. Steve stated that we should define "successful" term since it could be very subjective. As an item of open business, it was noted that we need to amend the by-laws to include these prerequisites. Bob moved that SAPA allow non-voting Corporate Membership for an annual fee of \$250. Don seconded the motion. Discussion ensued to include the possibility of allowing Corporate members to advertise in the Newsletter. The motion was tabled for presentation at the BOD meeting on Friday.

11. **Sales Booth Committee:** Steve reported that purchases to restock the sales booth this year were approximately \$4,000. Steve reported the purchase of conference registrar embroidery shirts for \$895.32, golf towels for \$385.92, and office supplies for \$274.00, and store items for sale totaling \$2,812.67 (Enclosure 4). Yesterday's sales were \$1,350. Steve has switched from Sofee to a new vendor that is much more responsive and will even ship things on short notice. Steve stated that we were down to the last 50 SAPA coins. There was discussion of investigating color coins but no decision made. Steve said he would investigate recasting the SAPA coin to delete the "apostrophe s" after Physician on subsequent coin purchases.

13. **Technology:** Steve reported that the secretary turned in her computer and he would investigate the cost effectiveness of upgrading it. In the discussion of the technology upgrade plan, Frank stated that he did not need a laptop but needed Microsoft Suite Office 2003 software. Don moved that Steve purchase a laptop for the secretary and treasurer this year with Norton's, Word Perfect, Microsoft Office 2003, and XP Pro software as well as Microsoft Office 2003 software for Frank's laptop and external hard drives for all laptops. Paul seconded the motion and the motion carried. Steve stated he would investigate multiple licensing.

14. **Conference Registration Coordinator:** Bob submitted his expense report for 2005-2006 (Enclosures 5a & 5b). Total of all expenses for registration, other than individual travel, lodging and per diem was \$12,671.05. Bob stated that as of today there were 550 conference registrants and 39 exhibitors. Bob reported income from attendees, grantors, and exhibitors is approximately \$110,000. Bob noted that registrants were down from 618 last year which may be attributable to the current op-tempo. Bob noted difficulty inputting students last year as there was no clear category on the registration form. He recommended and the BOD agreed to a flat fee for students of \$60. Exhibitor

fees were discussed and it was agreed not to change them at this time. Conference Registration staff salaries were tabled until the Friday BOD meeting. Bob stated that Mike Roberts who was a member of SAPA, owned Data West, and was granting SAPA free access on the web for our website. This webmaster company was sold to Front FRII and while they are currently honoring the free access agreement, they could potentially start charging \$24/month as a fee for web space.

15. **Sean Grimes Scholarship Committee:** The chairman of the Sean Grimes Scholarship Committee, Don Black informed the BOD that he and committee members Polly, Sherry Womack, and Sherry Morrey had received three applications for this year's scholarship. He stated that 2 were incomplete but the one received from Kevin Wilkes was both complete and illustrative of Kevin being a highly qualified applicant. Don stated that Kevin would be presented a check for \$3,000 from the PA Foundation during the banquet. Don stated that the Grimes family paid for Kevin's trip to the conference from Naples, FL where he is attending PA school.

**OLD BUSINESS:** None

#### **NEW BUSINESS:**

1. Bob informed the BOD that it cost \$350 each year to rent a trailer to move all his equipment to the conference. In addition, he stated that often the specific trailer needed is not available at the closest rental site necessitating multiple trips to a more distant rental site. Bob suggested, and the BOD agreed that he and Steve investigate the possibility of purchasing a dual axle, 6' X 12' trailer for up to \$3,000 and present their findings to the BOD at a later date.

2. Steve informed the BOD that Nick Porter retired 1 January and that this would probably be his last year at the conference. Nick has been at every SAPA conference. Steve suggested that SAPA recognize Nick for his dedicated support of SAPA over many years and present it to Nick at an appropriate venue. Frank moved that SAPA purchase a plaque in honor of Nick's support of SAPA and award him honorary membership in SAPA. Paul seconded the motion and the motion carried.

3. Steve requested that BOD members, when responding to email chains regarding SAPA business, keep the topic pure rather than responding to multiple topics on one email message, in order to make it easier to monitor everyone's response. It was agreed that the secretary should keep a record of SAPA business conducted via email during the course of the year.

4. Officer Candidate Robert D. Coleman was selected as the Army representative on the Interservice Physician Assistant Student Society (IPASS) team to compete in the National Medical Challenge Bowl. On behalf of Sherry

Morrey, Casey presented a request for SAPA to sponsor Officer Candidate Robert D. Coleman to attend the 34<sup>th</sup> Annual American Academy of Physician Assistants (AAPA) Conference being held 27 May-1 June 2006 in San Francisco, CA. Don moved that SAPA sponsor OC Coleman in the amount of \$1,500. Frank seconded the motion and the motion carried. Enclosed is a copy of the letter to OC Coleman informing him of SAPA's sponsorship (Enclosure 6).

5. Jim informed the BOD of the need to decide on the number and amount of any SAPA scholarships this year, poster awards, and donation to the Veteran's Caucus. These items were tabled until the Friday BOD meeting.

6. Casey stated that the newsletter would be transitioning to electronic distribution. Bob stated that when a new issue was posted on the SAPA web site, he could email members to notify them of the new posting. Further discussion on this topic was tabled until the Friday BOD meeting.

7. The next BOD meeting will take place Friday, 28 April, in the hotel restaurant.

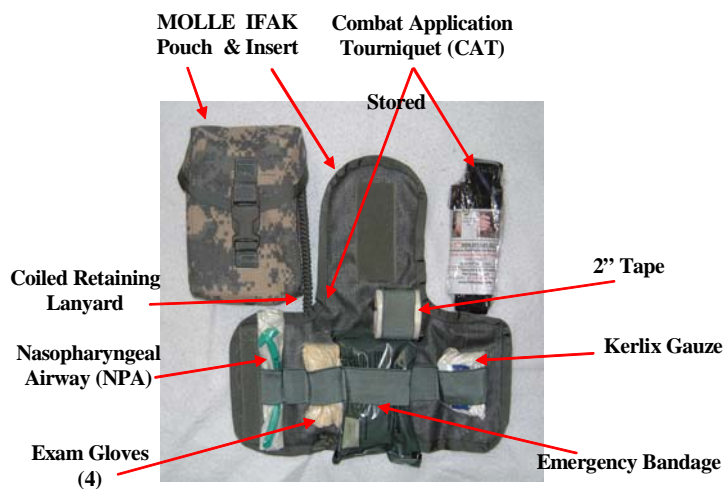
#### **ADJOURNMENT:**

Hearing no further business, Steve entertained a motion to adjourn. Jim so moved, Paul seconded the motion and the motion carried. The meeting adjourned at 1400 hrs.

Respectfully submitted by: Casey Bond, Acting Secretary  
Approved by: Steve Ward, President

### **Improved First Aid Kit (IFAK)**

**By Donald Parsons**



A small convoy of military vehicles drives down a dusty road in Iraq. There is suddenly a load explosion and a cloud of dust and smoke envelopes the vehicles. There are screams from injured soldiers and chaos overwhelms those who are not hurt trying to figure out what just happened. As the dust clears there are the burning remains of an up armored M1114. Three soldiers riding in that vehicle lay scattered on the ground around its remains. They are in various conditions of injury, one is missing an arm and leg, another in unconscious with

multiple fragmentation wounds along his right side, the side closest to the explosive device, and the last poor soul lies in a pool of blood with a large gaping wound to the right side of his head, he is beyond repair. The only medical equipment each soldier carries is an outdated battle dressing in a compass pouch. This battle dressing has been the standard first aid dressing since the Korean War, and is the only piece of medical equipment carried by individual soldiers. For the soldiers injured in today's attack it will do little to treat their injuries. If only the uninjured soldiers had some way to treat the life threatening injuries their buddies have incurred. This would have been a tragic scene several months ago but these soldiers have just been issued their new Improved First Aid Kit (IFAK). Within this kit is enough medical equipment to treat the most common preventable causes of death and injury in combat today. The Combat Application Tourniquet can stop severe bleeding from an extremity wound. In conjunction with the Emergency bandage and the roll of Kerlix gauze we can control most other bleeding wounds even if there are multiple injuries. For soldiers deployed into the CENTCOM theatre, they will also have a hemostatic bandage to help control non-extremity wounds that are bleeding severely. There is the plastic wrapper on the battle dressing that can serve as an occlusive dressing to seal penetrating chest wounds, and a roll of tape to secure it to the casualty's chest. A nasal airway (NPA) is included to help keep that unconscious casualty's airway open, while getting them ready for evac. In addition, while providing this care each soldier can protect himself by applying latex gloves when working on the the injured soldiers. While we were not able to save everyone, like the soldier with the massive head injury, we know what the preventable causes of death are. The IFAK is designed to address these preventable causes of death. Extremity hemorrhage, tension pneumothorax, and airway compromise are the preventable causes of death in combat today. Hemorrhage is addressed by three of the components of this kit, the CAT tourniquet, along with the Emergency Bandage and the roll of Kerlix gauze are all designed to stop bleeding. Over 60% of all wounds are extremity wounds and some of these are severe. Hemorrhage continues to be the leading cause of preventable death in combat today. The new hemostatic Hemcon Bandage, will stop arterial bleeding. We have never had a bandage that would stop arterial bleeding before. Training may be an issue with this new bandage, as many soldiers have never seen one or been taught to use it properly. The plastic wrapper from the Emergency Bandage and roll of tape can make an occlusive dressing for a penetrating chest wound. While penetrating chest wounds are much less common when body armor is worn properly they do still

occur, and can be rapidly fatal if a tension pneumothorax develops. If the individual does not have a needle to perform needle chest decompression, then how can they relieve a tension pneumothorax? The only solution is to remove the occlusive dressing and see if that helps relieve the pressure. If not, then the next step is put on the gloves if you have not already, and to stick a finger into the wound to try and release the pressure build-up. Issuing needles to non-medical personnel to relieve a tension pneumothorax is a very controversial issue. However in a recent evaluation of SOF soldiers who died in combat, up to 7% of these individuals died from a tension pneumothorax. Many leaders are afraid that untrained individuals sticking needles into a casualty's chest will cause more harm than good. However, let's look at why and how this lifesaving measure should be accomplished. If a casualty has a penetrating wound to his chest he will have a pneumothorax secondary to the penetrating wound. If the casualty does not improve with placement of an occlusive dressing and positioning the casualty (they should be sitting up), and their respirations continue to get worse (progressive respiratory distress), this is the indication that a tension pneumothorax is developing and should be treated with needle chest decompression. The question always arises about what if the casualty doesn't have a tension pneumothorax? Well, if the casualty has a penetrating wound to his chest we know he has a collapsed lung. In addition, the hole in his chest is probably a lot larger than the diameter of the needle being placed in his chest. So, are we really causing more damage by placing the needle into the chest if the casualty does not have a tension pneumothorax? The answer is no. A tension pneumothorax can be rapidly fatal, if not treated whereas; a regular pneumothorax can survive for an extended period. The nasopharyngeal airway has the advantage over the oral pharyngeal airway in that it can be inserted in a conscious or semi-conscious casualty, and stays in place better. This device will allow the casualty's airway to remain open. It must also be stressed that when using an NPA the casualty must be placed in the recovery position, as the NPA will not prevent the tongue from blocking the airway if the casualty is left on his back. New information from the evaluation of the soldiers who have died in Iraq and Afghanistan indicate that airway problems may play a more important role in the cause of death than before. It should also be emphasized that soldiers with airway problems should be allowed to seek the position where respiration is easiest for them. Do not force them to lie down if it is more difficult for them to breathe in that position. Many times soldiers with airway problems may only need positioning to help relieve their airway troubles. Exam gloves are included in the kit to help prevent transferring body fluids between the care provider and the casualty. They should be used any time care is being given. We know that the majority of soldiers die on the battlefield in just a few minutes after wounding. There are a limited number of care

providers available on the battlefield. The tactical situation may prevent the combat medic or the combat lifesaver from reaching the injured soldier. If every soldier now has the ability to treat the preventable causes of death then they can provide self-aid or buddy-aid. This becomes a significant combat multiplier for the unit and will help to save more soldiers lives. Training is an important issue anytime new equipment is issued to soldiers. Without training on this new first aid kit soldiers will not be familiar with the components of the kit and will not understand how to use it. It is imperative that units conduct training on this kit prior to issuing it to soldiers. They must practice with each component for familiarity and not have to use it for the very first time on an actual casualty.

*The preceding article is a reprint from the MAR/APR issue in which I inadvertently omitted portions of the article. (CB)*

## PREVENTION AND TREATMENT OF COMBAT PTSD

By Frank Piper, MS, PA-C

### Part 1

#### Abstract

PTSD has been described as a normal response to an abnormal, traumatic event. There has been a great deal of research on military PTSD, mostly focused on the experiences of veterans during wartime. Recent studies have shown that there are certain risk factors that predispose some populations to developing PTSD, and that there is a correlation between previous trauma exposure, severity of symptoms and success in treating these individuals. Other factors, such as preexisting comorbid anxiety, depression, substance abuse or other psychiatric disorders further complicate the treatment and prognosis of this disorder. While there is no definitive treatment or cure, some methods or treatment appear to be effective in mitigating the symptoms of this disorder. This paper will examine the history of this malady, at-risk populations, current treatment options, and research efforts to reduce the common resulting symptoms of depression, isolation, rage, sleep disturbances, anxiety and intrusive thought that plague this population whom we place in harms way.

#### What is Post-Traumatic Stress Disorder?

There are several diagnostic criteria for PTSD, but the hallmark is exposure to a “traumatic stressor”. This traumatic stressor or event, could involve actual or threatened death or serious injury, witnessing an event that involves death or injury, learning about an unexpected or violent death or serious harm, or the threat of death or injury of someone close. (1) Examples include exposure to wartime combat, rape, physical abuse, or witnessing someone else being badly injured or killed. Other examples that are not related to directly experiencing the trauma, but are nonetheless just as potentially problematic, are treating patients or handling remains of trauma victims (particularly dismemberment or capitation) such as after a civilian disaster or war battle These would be considered a traumatic stressor. Additional diagnostic criteria include persistent reexperiencing of the traumatic event that can manifest traumatic nightmares, daytime fantasies, and psychotic reenactments known as PTSD flashbacks, and avoidance behavior (the person will avoid anything that might remind them of the trauma.) (Table 1) People

with PTSD also often display symptoms that resemble those associated with anxiety disorder such as insomnia, irritability or hypervigilance. Research has shown that PTSD can persist for decades and, in some persons, for a lifetime and is often marked by remissions and relapses. (2)

#### Case Presentation

“My marriage is falling apart. We just don’t talk any more. Hell, I guess we’ve never really talked about anything, ever. I spend most of my time at home alone in the basement. She’s upstairs and I’m downstairs. Sure we’ll talk about groceries and who will get gas for the car, but that’s about it. She’s tried to tell me she cares for me, but I get real uncomfortable talking about things like that, and I get up and leave. Sometimes I get real angry over the smallest thing. I used to hit her when this would happen, but lately I just punch out a hole in the wall, or leave and go for a long drive. Sometimes I spend more time on the road just driving aimlessly than I do at home.

“I really don’t have any friends and I’m pretty particular about who I want as a friend. The world is pretty much dog eat dog, and no one seems to care much for anyone else. As far as I’m concerned, I’m really not a part of this messed up society. What I’d really like to do is have a home in the mountains, somewhere far away from everyone. Sometimes I get so angry with the way things are being run. I think about placing a few blocks of C-4 (military explosive) under some of the sons-of-bitches. A couple of times a year, I get into fights at bars. I usually pick the biggest guy. I don’t know why. I usually get creamed. There are times when I drive real crazily, screaming and yelling at other drivers.

“I usually feel depressed. I’ve felt this way for years. There have been times I’ve been so depressed that I won’t even leave the basement. I’ll usually start drinking pretty heavily around these times. I’ve also thought about committing suicide when I’ve been depressed. I’ve got an old .38 that I snuck back from Nam. A couple of times I’ve sat with it loaded, once I even had the barrel in my mouth and the hammer pulled back. I couldn’t do it. I see Smitty back in Nam with his brains smeared all over the bunker. Hell, I fought too hard then to make it back to the World (U.S.): I can’t waste it now. How come I survived and he didn’t? There has to be a reason.

“Sometimes, my head start to replay some of my experiences in Nam. Regardless of what I’d like to think about, it comes creeping in. It’s so hard to push back out again. It’s old friends, their faces, the ambush, the screams, their faces (tears)... You know, every time I hear a chopper (helicopter) or see a clear unobstructed tree-line, a chill goes down my back; I remember. When I go hiking now, I avoid green areas. I usually stay above timber line. When I walk down the street, I get real uncomfortable with people behind me that I can’t see. When I sit, I always try to find a chair with something big and solid directly behind me. I feel most comfortable in the corner of a room, with walls on both sides of me. Loud noises irritate me and sudden movement or noise will make me jump.

“Night is hardest for me. I go to sleep along after my wife has gone to bed. It seems like hours before I finally drop off. I think of so many of my Nam experiences at night. Sometimes my wife awakens me with a wild look in her eye. I’m all sweaty and tense. Sometimes I grab for her neck before I realize where I am. Sometimes I remember the dream; sometimes it’s Nam, other times it’s just people after me, and I can’t run anymore.

“I don’t know, this has been going on for so long; it seems to be getting gradually worse. My wife is talking about leaving. I guess it’s no big deal. But I’m lonely. I really don’t have anyone else. Why

Why am I the only one like this? What the hell is wrong with me?"

The above description of one Vietnam veteran's problematic lifestyle, more than ten years after the war in Southeast Asia, is unfortunately not an unusual phenomenon. (3)

#### History of PTSD

Early references documented the military's recognition of soldiers being emotionally affected to such an extent that they were unable to continue fighting. Some examples were, in 480 BC the King of Sparta was quoted as saying he had, "Troops with no heart for the fight." Wellington at Waterloo in 1815 noted that while every soldier experienced fear, "All soldiers run away...the good ones return." During the early 1800's military doctors began diagnosing soldiers with "exhaustion" following the stress of battle during the Civil War. This "exhaustion" sometimes called "melancholia" was characterized by mental shutdown due to individual or group trauma, and in 1876 Dr. Mendez DaCosta published a paper describing the signs and symptoms that we associated today with PTSD, such as cardiac arrhythmias, heightened startle responses, and hyper-vigilance. The only treatment for this "exhaustion" was to bring the afflicted soldiers to the rear for a period of rest and recuperation and then send them back into battle.

Around this same a syndrome know as "railway spine" or "railway hysteria" was identified in England in people who had experienced the catastrophic railway accidents of the period. Again, the symptoms they exhibited were strikingly similar to the PTSD of today. During WWI soldiers experiencing overwhelming mental fatigue were diagnosed as having "soldier's heart" and "the effort syndrome". The British treated their affected soldiers by sending them back to England for treatment – and the soldiers almost never came back to the front. IN fact, some 60,000 British forces were diagnosed with "shell shock" and 44,000 of these were retired from the military because they could no longer function in combat. The French decided they couldn't afford that, so they treated their soldiers right at the front lines, and had much better success.(4)

The term "shell shock" emerged during WWI, followed in WWII by the term "combat fatigue." These terms were used to describe those veterans who exhibited stress and anxiety as the result of combat trauma. The official designation of "Post Traumatic Stress Disorder" did not come about until 1980 when the Third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was published.

The initial definition of PTSD described a psychological condition experienced by a person who had faced a traumatic event which caused a catastrophic stressor outside the range of usual human experience (an event such as war, torture, rape, or natural disaster). This definition separated PTSD stressors from the "ordinary stressors" that were characterized in DSM-III as "Adjustment Disorders", such as divorce, failure, rejection and financial problems. (5)

What causes Post-Traumatic Stress Disorder? How common is it? Who gets it?

Epidemiologists have asked these questions, and two major epidemiological studies have produced some answers. The National Vietnam Veterans Readjustment Survey (NVVRS), conducted between November 1986 and February 1988, comprised interviews of 3,016 American veterans selected to provide a representative sample of those who served in the armed forces during the Vietnam era. The National Comorbidity Survey (NCS), conducted between September 1990 and February 1992, comprised interviews of a representative national sample of 8,098 Americans aged 15 to 54 years. The following summary of these two surveys is excerpted from the Fact Sheet published by the VA National Center for PTSD, Research and Education on Post-Traumatic Stress Disorder.

The National Comorbidity Survey Report provided the following information about PTSD in the general adult population:

The estimated lifetime prevalence of PTSD among adult Americans is 7.8%, with women (10.4%) twice as likely as men (5%) to have PTSD at some point in their lives. This represents a small portion of those who have experienced at least one traumatic event. The most frequently experienced traumas were:

- Witnessing someone being badly injured or killed
- Being involved in a fire, flood, or natural disaster
- Being involved in a life-threatening accident
- Combat exposure

The majority of the people in the NCS experienced two or more types of trauma. More than 10% of men and 6% of women reported four or more types of trauma during their lifetimes.

The traumatic events most often associated with PTSD in men were rape combat exposure, childhood neglect, and childhood physical abuse. For women, the most common events were rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.

None of these events predictable produced PTSD in those exposed to it, and a particular type of traumatic event did not necessarily affect different sectors of the population in the same way.

The NCS report concluded, "PTSD is a highly prevalent lifetime disorder that often persists for years. The qualifying events for PTSD are also common, with many respondents reporting the occurrence of quite a few such events during their lifetimes."

The National Vietnam Veterans Readjustments Survey (NVVRS) report provided the following information about PTSD among Vietnam War veterans:

The estimated lifetime prevalence of PTSD among American Vietnam theater veterans is 30.9% for men and 26.9% for women. An additional 22.5% of men and 21.2% of women have had partial PTSD at some point in their lives. Thus, more than half of all male Vietnam veterans and almost half of all female Vietnam veterans-about 1,700,000 Vietnam veterans in all-have experienced "clinically serious stress reaction symptoms."

15.2% of all male Vietnam theater veterans (479,000 out of 3,140,000 men who served in Vietnam) and 8.1% of all female Vietnam theater veterans (610 out of 7,200 women who served in Vietnam) are currently diagnosed with PTSD. ("Currently" means 1986-88 when the survey was conducted.)

The NVVRS report also contains these figures on other problems of Vietnam veterans:

Forty percent of Vietnam theater veteran men have been divorced at least once (10% had two or more divorces), 14.1% report high levels of marital problems, and 23.1% have high levels of parenting problems.

Almost half of all male Vietnam theater veterans currently suffering from PTSD had been arrested or in jail at least once – 34.2% more than one-and 11.5% had been convicted of a felony.

The estimated lifetime prevalence of alcohol abuse or dependence among male theater veterans is 39.2%, and the estimate for current alcohol abuse or dependence is 11.2%. The estimated lifetime prevalence of drug abuse or dependence among male theater veterans is 5.7%, and the estimate for current drug abuse orr dependence is 1.8%. (6,7)

#### Risk Factors

When researchers began studying PTSD, it became clear that not all trauma survivors developed a permanent disorder. In fact, many recovered. The search for risk factors that increase vulnerability to chronic PTSD began early in the history of the disorder. Numerous

# **SOCIETY OF ARMY PHYSICIAN ASSISTANTS**

**P.O. BOX 07490**

**Fort Myers, FL 33919**

**First Class**

## **ADDRESS CORRECTION REQUESTED**

studies have noted a dose-response relationship between trauma severity and PTSD. However, epidemiological research has found the rate of exposure to trauma to far outweigh the prevalence of PTSD, indication that most people do not ever develop PTSD following a traumatic event. (8) Research in this area has identified the following important risk factors:

**Environmental Risk Factors** – A history of exposure prior to the focal trauma is also an important risk factor. A history of prior exposure to trauma or to chronic stress is an extremely potent risk factor for PTSD (9), particularly if it is experienced at a young age (10). In addition, studies have found that the type of social support is associated with lower levels of symptoms (11, 12).

**Demographic Risk Factors** – A consistent finding has been that the prevalence of PTSD is almost twice as high in women as it is in men. (8) To date, there are no firm explanations for this finding, although gender (being female) is also a risk factor for other psychiatric disorders. It is likely, however, that the higher risk for PTSD in females is primarily due to a particular vulnerability to assaultive violence. (13) Assaultive violence is also more threatening and injurious to females, with most perpetrators being male and therefore wielding greater physical strength. (13) Lower levels of education and income, and being divorced or widowed are risk factors PTSD. In addition, some studies have reported a higher risk for PTSD amongst ethnic minorities (8).

However, ethnic differences alone may not be a predictor of PTSD, as several other demographic factors also affect the risk of trauma exposure including gender, age, and socioeconomic status, as well as ethnicity. (8). This observation is important in the consideration of risk since trauma exposure does not occur in a vacuum. It may also be hypothesized that some of the predictors of PTSD may actually be predictor of trauma exposure.

**Prior Psychiatric Disorders and Personality Dimensions** – A past history of behavioral or psychological problems has also been associated with the development of PTSD (McFarlane, 1989). In fact,

prior affective, anxiety or substance abuse disorders all represent risk factors for the development of PTSD, and having a psychiatric history is thought to be a stronger predictor of PTSD than having a history of any specific psychiatric disorder. (8)

**Dissociation** – Peritraumatic dissociation appears to be an important risk factor for the development of PTSD (15), and PTSD subjects show elevated scores on measures of dissociative symptoms (16). In a prospective study of injured trauma survivors, a study in 1996 (17) found peritraumatic dissociation to be the best predictor of PTSD symptoms at 6 months post-trauma. Dissociative reactions may also be adopted as a maladaptive coping strategy in response to childhood trauma or chronic stress (18), and may partially mediate the relationship between prior traumatization and increased vulnerability to PTSD in the future.

**Cognitive Risk Factors** – Lower intellectual functioning has been found to be a risk factor for the development of PTSD. In one study, soldiers' IQ was assessed prior to entering a combat situation and a post combat analysis found that lower precombat intelligence levels are associated with increased risk of developing PTSD on exposure to combat. (19) This association remained significant even once an adjustment was made for degree of combat exposure. Controlling for degree of combat exposure is important because individuals with lower premorbid IQs are often placed in heavier combat situations than others.

Individuals with PTSD show increased neurological soft signs, indicative of subtle nervous system dysfunction. They also have a larger number of developmental problems, suggesting that there are preexisting impairments in neurodevelopment which act as risk factors for the development of PTSD (20). PTSD is also associated with specific impairments in explicit memory.

**The preceding article has been serialized due to large size and will be continued in subsequent issues. (CB)**