



# SAPA JOURNAL



## The Society of Army Physician Assistants

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### Critical Skills Retention Bonus(CSRB) Update

Two very important things happened on 12 Sep 06. The first one was my youngest daughter turned 26 years old. The second one, and perhaps more important to you, was I had the privilege to attend a Video Teleconference during which the following information was presented by LTC Mike Robertson, PA Consultant, SP Corps.

#### Bottom Line Up Front

- 25K per year - for a 4 year contract
- 20K per year - for a 3 year contract
- 10K per year - for a 2 year contract
- 5K per year - for a 1 year contract

#### Who's Eligible?

- All active component PA-Cs who are past their initial active duty service obligation (ADSO)
- Must receive commander (field grade) verification and recommendation of eligibility
- Must have
  - NCCPA certification
  - OBC graduate
  - privileges to practice
- Loss of these qualifications = loss of CSR
- Retiree Recalls also eligible

#### Window of Opportunity

- Effective date of implementation is:
  - 01 OCT 06
- Expiration date is NLT:
  - 31 DEC 09
- (unless superseded sooner; at discretion of TSG)

### Application

- Not automatic; must submit application
- “An officer who upon objective evaluation, determines that they will not meet the eligibility criteria for receipt of the pay, is obligated NOT to request CSR”
  - These cases will be referred to TSG
- Application is in memorandum format and directions for submission found in HQDA message

### Payment

- Will be directly through DFAS
- May experience delays up to 60 days upon receipt of agreement
- Will be in lump sum annually on agreed upon effective date

### Reassessment Process

- Re-look success rate and effectiveness in 2<sup>nd</sup> QUARTER FY07
- Will resubmit in 2009 for another 3 years if inventory is still low.

I have tried to present the content of this brief in its entirety, without editing, in order to accurately represent what LTC Robertson discussed. I have known Mike for over thirty years and I can attest to the fact that there is no stronger advocate for Army Physician Assistants, past or present. This initiative has been a long time in the making and although Mike would downplay his role in his usual self deprecating style, I am certain it would not have happened without his hard work and dedication. Airborne! (CB)

### Congratulations to the first PA Flag Officer!

Join me in congratulating RADM Michael Milner on his promotion and appointment as Assistant US Surgeon General. Admiral Milner trained at the Sheppard PA program in the early '80's and was an AF PA before transferring to the Public Health Service.

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

## Welcome to the Newest Member of the BOD

Received by CPT Richard V. Tea, PA-C

Hello everyone, my name is Richard Tea. As some of you have already known that I just got elected to be the new Reserve Director for Society of Army Physician Assistant. I grew up in Brooklyn, New York. I went to Brooklyn Friends High School. I graduated from Adelphi University in Garden City, New York with a Bachelor of Science in 1989. I received a Physician Assistant Certificate in December, 1994 from Cornell University Medical College, Physician Assistant with surgical focus. I joined the Army Reserve in July of 1991 as an enlisted with a rank of SPC (E4). I went to Fort Knox, Kentucky for my Basic Training and went on for my AIT (Advanced Individual Training) at Fort Sam Houston in Texas. I was directly commissioned as a 2LT in May of 1995 after I graduated from the PA school. I was assigned to a USA Hospital. I am current assigned to a Medical Support Unit in Brooklyn, New York. I volunteered for a Nuevo Horizon (a humanitarian mission) in Guatemala where we helped build schools and wells and gave medical assistance to the locals. After September 11, 2001, I was mobilized with my unit for eighteen months to provide medical support for our war trade mission at Fort Dix Soldier Processing Center. In my civilian job, I am working at Englewood Hospital and Medical Center in Cardiothoracic Surgery Department. I worked one year at New York Hospital and five years at Mt Sinai Hospital and Medical Center before I joined a new cardiac surgery department at Englewood Hospital. Why I run for a Reserve Director? Well, I have been a SAPA member for several years. I have been in the reserve for total of 14 years. Shortly before the election, I opened my AKO email and got an email from LTC Frank Piper asking if anyone interested to run for a Reserve Director. I took the opportunity because this is what I have wanted to do so I can help and hopefully make some changes for our new coming colleague reservist PAs. I was one of the first PAs who was mobilized after September, 11. I know what it was like to not be able to get helps or even ask questions pertaining mobilized PA. I did not know where to turn to but just to get along with the flow. I know what needs to be done to get promoted. I know where to get helps. My goal as a Reserve Director is to act as a liaison and POC for all reserve PAs. I want to be the guidance counselor for reserve PAs. I have been in the reserve long enough for me to say that I have the experience. My philosophy about this is that everybody can learn from somebody. One thing I have learned is that no one knows everything. Learning is a process. There are issues that I want to address at later time as a Reserve Director. I hope I do not bore you too much about myself. I will do my very best to help reserve PAs and newly commissioned PAs in any way possible.

OCTOBER 2006

## PREVENTION AND TREATMENT OF COMBAT PTSD

By Frank Piper, MS, PA-C

### *Part 2*

**Biological Risk Factors** – The study of biological risk factors has identified several abnormalities that are present in trauma survivors with PTSD. Because these alterations were not observed in similarly exposed persons without PTSD, they are likely to be related to the pathophysiology of PTSD, and not simply to exposure to trauma. Shalev et al. (1998a) In a study in 1988, the heart rate in 86 trauma survivors was assessed at the time of presentation to the ER. Subjects who later developed PTSD were found to have a higher heart rate at time of presentation compared to those who did not develop PTSD, consistent with there being an enhanced or prolonged catecholamine response to the trauma in this group. Heart rate no longer distinguished the PTSD and non PTSD groups at one month follow-up. (21)

Another potential risk factor for the development of PTSD is that both combat related and civilian PTSD are associated with chronically low levels of cortisol. Cortisol is a glucocorticoid secreted by the hypothalamic-pituitary-adrenal (HPA) axis. Underlying this observation are systematic alterations in overall HPA axis activity, which appear to be unique to PTSD. (22)

**Familial or Genetic Risk Factors** – There are some findings that suggest familial transmission of PTSD. For instance, trauma survivors with PTSD are more likely to have parents and first-degree relatives with mood, anxiety, and substance abuse compared with trauma survivors who did not develop PTSD. (23) More recently, Yehuda et al. (1998b) demonstrated that Holocaust survivors with PTSD are more likely to have children with PTSD compared to Holocaust survivors without PTSD.

### **Prevention Strategies**

**Debriefing** – The use of debriefing following an exceptionally stressful event formally entered Army doctrine in the early 1990s. Designed to be conducted by specially trained teams, the concept was not conceived as “therapy or counseling”, but rather, a proactive intervention for normal individuals who have survived an abnormal, and severe stressor. The model most often employed follows the guidance provided by James Mitchell called Critical Incident Stress Debriefing. CISD is a highly structured model of group crisis intervention. Conducted in a formal meeting, usually with small groups, CISD is generally held shortly after an unusually stressful incident, and focuses upon dealing with the emotion associated with the event. Within the Army, this method has been employed following a myriad of stressful events, to include combat experiences, training accidents, aviation mishaps, and soldier suicides.

**Repatriation** – Repatriation on the other hand, is an “operational” mission as opposed to a medical or psychological intervention, but has its place in the mitigation of PTSD symptoms. Repatriation is a process of reintegrating U.S. military personnel, and others, who have been prisoners of war held as hostages by terrorists, detained in peacetime by a hostile foreign government, evaded enemy capture, or were otherwise isolated or missing under hostile conditions. An integral aspect of repatriation involves “Psychological debriefing” as well as “decompression,” – involving informal sessions, as opposed to formalized intervention. It is important to note that there is a very specific repatriation protocol developed by the Joint Personnel Recovery Agency (JPRA) involving tactical, intelli-

gence, and personnel recovery debriefing in addition to psychological debriefings.

For all casualties, irrespective of “category”, contact with family was supported and encouraged, via telephone calls, video links, and e-mail. However, reunions are not encouraged prior to the casualties’ return to CONUS. Combatants are also required to rest, readjust, and decompress prior to handling even normal family interactions. A recent example of this was readily apparent with the rescue of PFC Jessica Lynch and other members of the 507<sup>th</sup> Maintenance Company in Nasiriyah, Iraq on April 1, 2003. These soldiers were ambushed on March 23, 2003 and held as POWs. Eight of their comrades were killed in action. The surviving soldiers were taken to Landstuhl Regional Medical Center in Germany and received medical treatment, and were debriefed, and decompressed for a full week before returning to Walter Reed Army Medical Center in Washington, D.C. where PFC Lynch continues to receive rehabilitation treatment. During the initial phase of their repatriation, no family reunions were scheduled or encouraged.

An important aspect of providing emotional support for soldiers have lost comrades is to assist in the grieving process. Sometimes their grieving course is complicated by their inability to participate in the memorial services, typically due to their own injuries, as well as geographical separation from the memorial service. To assist in providing closure, these soldiers should be given the opportunity to participate in the “Fallen Service Member Ceremony”. While this is quite an emotional experience, it can be an important one in honoring their comrades, and addressing potential feeling of their own guilt in surviving the ordeal. (25)

#### Treatment

There are some patients for whom any early intervention may be inappropriate. The following issues are commonly encountered in individuals with PTSD, and must be carefully addressed before considering treatment options for these individuals. At risk individuals may have some or all of the following in varying degrees: excessive avoidance, dissociation, anger, grief, extreme anxiety, catastrophic belief, prior trauma.

If any of these symptoms are too distressing to engage in potentially invasive therapy, allow the posttraumatic upheaval to settle before directly addressing the traumatic memories, and take a supportive approach until the patient is better able to use therapy. (25, 26)

A word about comorbidity. Comorbid disorders such as substance abuse, depression and suicide risk may also be exacerbated by the distress elicited by exposure therapy. Borderline personality disorder and psychotic disorders may be particularly affected. If deterioration of preexisting disorders is present, it is best to offer support to contain the preexisting disorder first.

Treatment for PTSD should begin with a detailed evaluation of both physical and mental status, and development of a treatment plan that meets the unique needs of the patient. There are several good screening instruments, but I recommend the Clinician-Administered PTSD Scale (CAPS). CAPS is a structured clinical interview designed to assess adults for the seventeen symptoms for Post Traumatic Stress Disorder (PTSD) outlined in DSM-IV, along with five associated features (guilt, dissociation, derealization, depersonalization, and reduction in awareness or surroundings). Prior versions of the CAPS (CAPS-1 and CAPS-2) were designed to assess current or lifetime PTSD status or PTSD symptoms over the previous week, respectively. The current version of the CAPS incorporates each of the previous versions’ features. The CAPS provides a means

to evaluate:

- self-reports of exposure to potential Criterion A events;
- current and/or lifetime DSM-IV diagnosis of PTSD;
- the frequency and intensity of each symptom;
- the impact of the 17 PTSD symptoms on social and occupational functioning;
- the overall severity of PTSD;

The CAPS is available from the National Center for PTSD for a nominal fee, to mental health professionals with advanced training in the administration of diagnostic instruments for clinical or research purposes. A manual for administration is also available.

Generally, PTSD-specific-treatment is begun only when the survivor is safely removed from a crisis situation. For instance, if currently exposed to trauma (such as by ongoing domestic or community violence, abuse, or homelessness), severely depressed or suicidal, experiencing extreme panic or disorganized thinking, or in need of drug or alcohol detoxification, addressing these crisis problems becomes part of the first phase of treatment.

The goal of treatment is to eliminate or mitigate PTSD symptoms by:

- Educating trauma survivors and their families about how persons get PTSD, how PTSD affects survivors and their loved ones, and other problems that commonly come along with PTSD symptoms.
- Understanding that PTSD is a medically recognized anxiety disorder that occurs in normal individuals under extremely stressful conditions is essential for effective treatment.

Exposure to the event via imagery allows the survivor to re-experience the event in a safe, controlled environment, while also carefully examining their reactions and beliefs in relation to that event.

Examining and resolving strong feelings such as anger, shame, or guilt, which are common among survivors of trauma

Teaching the survivor to cope with post-traumatic memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Trauma memories usually do not go away entirely as a result of therapy, but become manageable with new coping skills.

Therapeutic Approaches Commonly Used to Treat PTSD:

Cognitive-behavioral therapy (CBT) involves working with cognitions to change emotions, thoughts, and behaviors. Exposure therapy is one form of CBT unique to trauma treatment, which uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context, to help the survivor face and gain control of the fear, and distress that was overwhelming in the trauma. In some cases, trauma memories or reminders can be confronted all at once (“flooding”). For other individuals or traumas it is preferable to work gradually up to the most severe trauma by using relaxation techniques and either starting with less upsetting life stresses or by taking the trauma one piece at a time (“desensitization”).

Along with exposure, CBT for trauma includes learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts (“cognitive restructuring”), managing anger, preparing for stress reactions (“stress inoculation”), handling future trauma symptoms, as well as addressing urges to use alcohol or drugs when they occur (“relapse prevention”), and communicating and relating effectively with people (“social skills” or marital therapy). Pharmacotherapy (medication) can reduce the anxiety, depression, and insomnia often experienced with PTSD, and in some cases may help relieve the distress and emotional numbness caused by trauma memories. Sertraline (Zoloft) was approved for treatment of PTSD in 1999, and is currently the only drug with an FDA indication. Sertraline has been shown to provide better results in women, which is

encouraging as women are more susceptible to the development of PTSD. The two major classes of antidepressants are selective serotonin reuptake inhibitors (SSRIs), such as Prozac, Zoloft, Paxil, and Luvox, and tricyclic antidepressants (TCAs), such as Elavil and Tofranil. These medications work by inhibiting the re-uptake of neurotransmitters, such as serotonin, resulting in the accumulation of these neurotransmitters. Brain chemicals such as serotonin are thought to be low in conditions such as anxiety and depression. Preventing their reuptake by the nerve cells essentially increases the amount of available chemical. Monoamine oxidase (MAO) inhibitors may also be used to treat PTSD and other anxiety disorders and function much the same as SSRIs and TCAs. Less frequently, benzodiazepines, such as Valium, Xanax and Serax, may be prescribed to treat anxiety, but they are highly addictive and can cause depression if overused. Worse than addiction is the tolerance effect that causes patients to take increasing quantities of the benzodiazepine until the drug stops working altogether. Tolerance to benzodiazepines can occur in as little as a few weeks. Withdrawal symptoms can include hyperanxiety, confusion, anorexia, shaking, memory loss, and reemergence of the original symptoms. There are alternatives to these medications. Propranolol (Inderal) may be used to counter performance anxiety. It works by blocking certain actions of the sympathetic nervous system, which causes patients to feel stress. This reduces sensations of anxiety such as tachycardia, palpitations, speeding thoughts, hand tremors, and nervousness. (27)

Eye Movement Desensitization and Reprocessing (EMDR) is a relatively new treatment of traumatic memories which involves elements of exposure therapy and cognitive behavioral therapy, combined with techniques (eye movements, hand taps, sounds) which create an alteration of attention back and forth across the person's midline. So far, this method has shown some benefit in civilian cases of PTSD, but its benefit in cases of combat related PTSD are equivocal. (28)

Group treatment is often an ideal therapeutic setting because trauma survivors are able to risk sharing traumatic material with the safety, cohesion, and empathy provided by other survivors. As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. The goal is for group members to discuss and share coping of trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, and prepare themselves to focus on the present rather than the past. Telling one's story (the "trauma narrative") and directly facing the grief, anxiety, and guilt related to trauma enables many survivors to cope with their symptoms, memories, and other aspects of their lives. (2)

Brief psychodynamic psychotherapy focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Through the retelling of the traumatic event to a calm, empathic, compassionate and non-judgmental therapist, the survivor achieves a greater sense of self-esteem, develops effective ways of thinking and coping, and more successfully deals with the intense emotions that emerge during therapy. The therapist helps the survivor identify current life situations that set off traumatic memories and worsen PTSD symptoms. (s)

#### Lifestyle Changes

Diet can help, as can avoiding simple sugars (like candy), which produce a blood sugar rush, followed by a nerve-racking bottoming out. Eating a variety of whole foods will replenish nutrients

essential to a healthy nervous system. Some patients may have hypoglycemia, which can mimic symptoms of an anxiety attack. Eating small frequent meals

#### Avoid Stimulants

Many anxious people are sensitive to caffeine. Patients should be cautioned to avoid coffee, tea and anything else containing caffeine, or switch to non-caffeinated varieties of these beverages. Chocolate and herb guarana also contain caffeine. Other stimulants will also produce unwanted anxiety, such as ephedra or ma-huang and should be avoided as well.

#### Dietary Supplements

Some alternative medicine proponents point out that deficiencies of many vitamins, minerals, amino acids, and fatty acids can "imbalance" the nervous system. A high-quality multivitamin and mineral formula that contain antioxidants and trace elements can correct these deficiencies. Some suggest adding a tablespoon of flaxseed oil daily to boost essential fatty acids.

#### Sleep Hygiene

Studies demonstrate that the consequences of not getting enough sleep are anxiety and irritability, along with a host of other unpleasant side effects. To address this, advise patients to follow a few simple suggestions. Try to make the bedroom a place only for sleep. Do not read, eat, or watch TV in the bedroom. This will help train your body to prepare for sleep the moment you lie down. Also avoid stimulating activities before going to bed, like reading a book, or exercising. And although alcohol is technically a depressant, it can greatly interfere with sleep patterns. Alcohol and cigarettes should be avoided before going to bed.

#### Exercise

Exercising 10 minutes before bedtime is obviously not a good idea, but setting a time of day for regular physical activity is a good habit to develop, including establishing a normal and healthy sleep pattern (29). It gets you out of your head, releases pent-up emotion, and afterward leaves your muscles toned and relaxed. Pick an activity that you enjoy, so that exercising becomes less of a chore and more of an enjoyment. Try walking, swimming, bicycling, jogging, yoga, tai-chi, skiing, tennis; even golf burns calories. Interestingly, a recent study found that leisure-time physical activity buffered people against physical symptoms and anxiety associated with minor stress. What mattered wasn't the person's level of aerobic fitness, but simply the regular participation in an enjoyable physical activity (30). Another study found that although light intensity exercise lowered anxiety, high-intensity exercise intensified feelings of anxiety (27). Some people feel it is necessary to work themselves practically to exhaustion while exercising, while the research indicates that light impact exercise on a regular basis is actually more effective. As in all things, moderation is the key.

#### Psychiatric disorders commonly co-occurring with PTSD

Psychiatric disorders commonly co-occurring with PTSD include: depression, alcohol/substance abuse, panic disorder, and other anxiety disorders. Although crises that threaten the safety of the survivor or others must be addressed first, the best treatment results may be achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol/substance abuse.

#### Complex PTSD

Complex PTSD (sometimes called "Disorder of Extreme Stress") is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse. Developmental research has shown that many

brain and hormonal changes may occur as a result of early, prolonged trauma, and contribute to difficulties with memory, learning, and regulating impulses and emotions. Combined with a disruptive, abusive home environment which does not foster healthy interaction may contribute to severe behavioral difficulties (such as impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-destructive actions), emotional regulation difficulties (such as intense rage, depression, or panic) and mental difficulties (such as extremely scattered thoughts, dissociation, and amnesia). As adults, these individuals often are diagnosed with depressive disorders, personality disorders or dissociative disorders. Treatment often takes much longer, may progress at a much slower rate, and requires a sensitive and structured treatment program delivered by a trauma specialist.

#### Research

The National Center for PTSD was created in 1989 within the Veteran's Administration (which has since become the Department of Veterans Affairs) in response to a Congressional mandate to address the needs of veterans with military-related post-traumatic stress disorders. The agency serves as a resource center for PTSD, and promotes and seeks to coordinate the exchange of information regarding all research and training activities carried out by the Veterans' Administration, and by other Federal and non-Federal entities, with respect to PTSD. The Center is a consortium among seven VA centers across the US, with headquarters in White River Junction, VT.

PILOTS (Published International Literature on Traumatic Stress) is a multidisciplinary database developed and maintained by the National Center for PTSD. PILOTS is the largest database devoted to traumatic stress literature in the world. It contains citation and abstracts for journal articles, books, and other published writings on traumatic stress. This ambitious undertaking promises to provide valuable information that will be used in future research to prevent and treat PTSD. The following are a sample of the types of research ongoing.

#### Biological

A group doing research with active-duty soldiers at the John F. Kennedy Special Warfare Center and School at Fort Bragg, NC have found a peptide called "Neuropeptide Y." It is a substance that, in addition to many other actions, works on the prefrontal cortex of the brain and allows one to stay focused on a task even under stress. They found that the Special Forces trainees – the green Berets – produced significantly more NPY than the Rangers and Marines who were going through the same training. Twenty-four hours after completing the training the Green Beret trainees were back to baseline levels NPY while the others were significantly depleted. There also was a clear, negative relationship between performance scores and the number of dissociative symptoms reported by the trainees and (a negative relationship) between NPY and dissociation. In other words, the less NPY soldiers had, the more they dissociated, and the more they dissociated, the worse they did in their training. This suggests that at least some physiological factors may predate the development of PTSD.

The research group also looked at trauma histories in their subjects to see whether a history of child abuse predicted differences when they went through training. Interestingly, those in the Green Beret units tended to have endured more child abuse but did better under stress. Trainees from the Rangers and Marines with a history of child abuse had more trouble during training. This has raised a key question meriting further investigation: Did the Green Beret

trainees come that way, or was there something in their previous training in the military that helped them perform better under stress? The presumption may be that by measuring NPY and other factors, the Army might be able to better select soldiers who will be better candidates for this special training. (4)

The PTSD Research laboratory at the Charlestown Navy Yard is a part of the Massachusetts General Hospital (MGH) Psychiatric Neurosciences Program and performs state-of-the-art psychobiological research into the assessment, pathophysiology, prevention, and treatment of post-traumatic stress disorder. The laboratory is presently conducting the following federally funded studies:

Positron emission tomographic study of cerebral blood flow during traumatic mental imagery in PTSD (R.K. Pitman, Principal Investigator). The major goal of this study is to evaluate which regions of the brain are selectively activated during traumatic re-experiencing.

Secondary prevention of PTSD with propranolol (R.K. Pitman, Principal Investigator). The major goal of this project is to investigate the effectiveness of the beta-adrenergic blocker propranolol in preventing the development of PTSD in persons presenting to the MGH Emergency Department following a traumatic experience.

Prospective psychophysiology study of risk for PTSD (S.P. Orr, Principal Investigator). The major goal of this project is to examine a promising set of pre-trauma psychophysiology, endocrinologic, and psychometric measures for their ability to predict the occurrence of PTSD following exposure to traumatic events in firefighter/EMT and police recruits.

Dr. Cary Savage of the Psychiatry Department at the Massachusetts General Hospital is conducting a research study to examine brain function in firefighters who suffer from post-traumatic stress disorder. Pharmacological

While there are large numbers of research projects on going, much is left to be learned regarding the efficacy of medication alone in treating PTSD patients. In a small study (187 patients) sertraline was shown to be efficacious for the acute treatment of patients with PTSD. (31)

Beta Blockers – Patients who received a short course of propranolol in shortly after a traumatic event were less likely than placebo recipients to have a physiological response when thinking about their trauma, according to finding from a recent pilot study. The incidence of PTSD symptoms did not significantly differ between the two study groups, but the findings do suggest that further exploration of preventive pharmacology for PTSD is warranted. (32)

Topiramate is an anticonvulsant that is chemically unrelated to any other anticonvulsant or mood regulating medication. The mechanism of action is unknown. While not FDA approved to treat any disease other than epilepsy, topiramate had a marked effect on 3 selected patients in reducing and even eliminating trauma-related intrusive memories and nightmares and normalizing depressed mood. These findings, together with observations in more than 30 additional patients (reported elsewhere), suggest that further study of topiramate as a treatment for PTSD is warranted. (33)

Paroxetine and Lithium – Because fifty to ninety percent of patients with PTSD present comorbid anxiety, depressive, substance abuse, or other psychiatric disorders, this combination of medications has shown some promise in selected patients. In these cases, most symptoms that paralleled the cycles of the depressive disorder, recurrent type, cleared within two weeks. (34)

## Conclusions

It is vital to have an appreciation of the precipitating experience – and an understanding that not all patients will be affected by PTSD in the same degree. The underlying premise to psychological debriefing and decompression is that the somatic, emotional, and cognitive reactions following a traumatic event are normal. It is extremely important that these strategies take place shortly after the event in order to minimize the likelihood of onset of the syndrome. If treated as psychiatric casualties, “psychologically broken” and “in need of fixing,” the natural tendency for human beings is to accommodate that expectation and become such patients. In patients where PTSD has already manifested itself, and has disrupted the social fabric of their lives, treatment modalities are varied and success results are mixed. Interventions based on pathological and diagnostically oriented treatment may well undermine the individual resilience of the soldier and should be used only when necessary. Instead, utilization of cognitive behavioral therapy along with judicious use of medications may offer the best help for these patients. (25) Finally, research is continuing on many fronts, and may provide better evidence based treatment options in the future.

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# **SOCIETY OF ARMY PHYSICIAN ASSISTANTS**

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## **ADDRESS CORRECTION REQUESTED**

the National Vietnam Veterans Readjustment Study. New York, Kulka, R; Schlenger, W; Fairbanks, J; et al: Trauma and the Vietnam War generation: Report of findings from Bruner Marzel, 1990.

### **TABLE 1**

#### **Diagnostic Criteria for Post-traumatic Stress Disorder**

The person has been exposed to a traumatic event in which both of the following were present:

The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

The person's response involved intense fear, helplessness or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

The traumatic event is persistently reexperienced in on (or more) of the following ways:

Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

Intense psychologic distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

Efforts to avoid thought, feelings or conversations associated with the trauma.

Efforts to avoid activities, places or people that arouse recollections of the trauma.

Inability to recall an important aspect of the trauma.

Markedly diminished interest or participation in significant activities.

Feeling of detachment or estrangement from others.

Restricted range of affect (e.g. unable to have loving feelings).

Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span).

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

Difficulty falling or staying asleep.

Irritability or outbursts of anger.

Difficulty concentrating.

Hypervigilance.

Exaggerated startled response.

Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month.

The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

Acute: If duration of symptoms is less than three months.

Chronic: If duration of symptoms is three months or more.

Specify if:

With delayed onset: If onset of symptoms is at least six months after the stressor.

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