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Mandatory Counseling in Post Deployment Military Members

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by

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This independent study, submitted by Christine Ainsworth in partial fulfillment of the requirements for the Degree of Master of Science from the University of North Dakota, has been read by the faculty advisor under whom the work has been done and is hereby approved.

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Abstract

Post-Traumatic Stress Disorder (PTSD) is the most prevalent war wound for deployed returning military members having affected over 120,000 men and women. Treatment of this disorder is essential to avoid long term detrimental health effects. At this time, treatment is only optional and many don't seek treatment at all. This project addresses the issue that a treatment option, counseling, should be mandated for post deployment military members. Review of the literature shows that with treatment, many of the symptoms can be relived considerably and sometimes completely resolved. A presentation presented to the 78th Medical Group staff accomplished the goal of making them aware of the signs and symptoms of this disorder and treatment options. It also made them aware that mandatory counseling should be considered.

Introduction

PTSD can have a significant impact on the lives of military members as well as their families. About 1,000 post deployment military members are diagnosed each week with PTSD (Zoroya, 2014). The symptoms range from rage and angry outbursts to isolation and avoidance. Long term effects from the disorder can be detrimental to health and wellbeing. There are actions in place for post deployment members but these are not mandated. Upon return from deployment, military members are required to fill a Post-deployment Health Risk Assessment (PDHRA) questionnaire about their deployment experience. This is done immediately upon return, at three months, at six months, and at one year after returning. The member also meets with a nurse and discusses the answer on the questionnaire. The nurse reflects on the service members record as well as assessing for any positive indicators for PTSD. A recommendation is made to see a medical provider for help; however, it is not mandated. One of the problems with the current procedure is that a service member may have "red flags" that could indicate a potential diagnosis of PTSD, and not be contacted by a psychiatric professional in a timely manner. Another problem is that the counseling is not mandatory, which could potentially result in the service member "slipping through the cracks" and not receive adequate or appropriate treatment. Research has shown that post deployment group counseling sessions have been proven to lower PTSD symptoms, as well as depression symptoms, and sleeping problems (Zinzow, Britt, McFadden, Burnette, & Gillespie, 2012).

Purpose

The purpose of this project is to educate the health care staff at the 78th Medical Group regarding the signs/symptoms of PTSD and to advocate the need for mandatory counseling for post deployment military members.

Post deployment members currently are not required to attend mandatory counseling in any of the armed service branches. It is, however, highly encouraged for them to get help if PTSD symptoms are present. Educating on the symptoms to those who encounter post deployment military members is valuable in order to encourage treatment. If those who encounter post deployers see the symptoms and understand how early intervention can be beneficial, then the health care staff will be supportive to mandatory counseling.

A PowerPoint presentation will be given to the members of the health care staff who encounter post deployment military members. The presentation will include signs/symptoms of PTSD as well as research based evidence of early counseling effects on reduction or elimination of the symptoms. Education will also be conducted on other treatment options and, the success in decreasing or eliminating symptoms. The treatment options include; a) counseling (cognitive behavior therapy, group, and family), b) medications, and c) yoga.

Significance

It is estimated that over two million soldiers have either deployed to Iraq or Afghanistan in the past decade and over a third of these soldiers have deployed more than once (Harmon, Hoyt, Jones, Etherage, & Okiishi, 2012). Many of these soldiers return with some type of mental health issue. These issues can significantly impact the lives of these soldiers in several ways

including; "job success, family stability, physical health, and social relationships" (Harmon et al., 2012, pg. 366).

In 1997, the Department of Defense (DOD) mandated that all returning soldiers, airman, marines, and sailors must complete a Post Deployment Health Assessment (PDHA), which is a two-part process of a mental and physical health screening with a health care provider (Harmon et al., 2012). This process proved to be unsuccessful for screening mental issues like PTSD. The military members returning from deployment did not always have PTSD symptoms right away and those who had symptoms upon returning found the symptoms subsided after a couple months of being home and did not return. The (DOD) changed the timing for the screenings to try and capture service members during the times they may have symptoms and renamed the assessment the Post Deployment Health Reassessment (PDHRA). The date ranges included in the updating screening process are initial return, 90 days, and 120 days. The Army also has included in their screening process a consultation with a mental health provider for a designated time of either 15, 30, or minutes based upon the answers provided on the PDHA (Harmon et al., 2012). These results are given to commanders who can then determine whether or not a member is fit for another deployment. The Air Force does not mandate post deployment counseling but they do mandate the PDHRA. The problem with these types of assessments is that service members may not answer them truthfully because of the stigma associated with receiving mental health care (McCarthy, Thompson, & Knox, 2012).

The Army has implemented one on one counseling for their returning deployers but the question lies if this is enough and should it be implemented throughout all forces? It can be quite intimidating to meet with a counselor one on one. It can also take several sessions to open up

about traumatic events to a complete stranger who many not have ever experienced a traumatic event large enough to cause PTSD.

Group counseling puts fellow military members together to discuss their feelings about deployment events. Group formats allow patients to feel validated and understood by those with similar experiences (Mott, Sutherland, Williams, Lanier, Ready, & Teng, 2013). Military members share a bond with deployments and may experience cohesion with other military members in-group counseling. Service members may find that speaking with someone about similar experiences, and possibly having the same type of stressors enables the individual to cope better with the disease. Some counseling programs will have a "battle buddy" that is available to the service member experiencing PTSD. That "battle buddy" is available as a support person to talk to the service members about past deployments. The "battle buddy" may have a better understanding of the service member's emotions and feelings and is able to relate

Theoretical Framework

Sister Callista Roy's Adaptation Model is the framework selected for this issue of PTSD. Roy's Adaptation Model (RAM) "focuses on an individual's adaptation to changeable environment and guides the assessment of individual's adaptation" (Abu Shosha and Al kalaldeh, M., 2012). The environment has both internal (originating from within the self) and external stimuli (originating from the environment). The types of stimuli in the environment might be; "individual culture, socioeconomic status, ethnicity and belief system, age, gender, and heredity" (Nayback, 2009).

Roy's model has four adaptive models; Physiological/Physical Mode, Self-Concept Mode, Role Function Mode, and Interdependence Mode. These modes allow us to observe

individual's behavioral responses to coping activities (Nayback, 2009). In Physiological Mode, the body reacts to PTSD by reducing plasma beta-endorphin concentrations which results in decreased pain threshold. The effect of this is during stress endorphins are released during the "fight or flight" response producing a calming effect to the individual, with PTSD the individual does not have this response (Nayback, 2009). This results in anxiety and agitation with just minimal stress.

Roy's Self-Concept Mode relates that the individual has a certain set of "beliefs and feelings about him or herself at a given time" (Nayback, 2009, pg 307). Individuals often believe they have control over their environment and have control over their own safety. PTSD decreases the likelihood the individual will feel this way and this decreased belief can result in the individual's health deteriorating physically, emotionally, and socially.

Roy's next Adaptive Mode is the Role Function Mode. In this mode, the individual relates to who he/she is in society (Nayback, 2009). Post deployers can often come back to their homes after several months not able to identify who they are in their families or society. This can often lead to distance or detachment from family or friends.

The final mode in RAM is Interdependence Mode. In this mode the focus is on "giving and receiving love, respect, and value" (Nayback, 2009, pg. 207). Individuals who experience PTSD often become emotionally numb so they will not have to share their traumatic experience with anyone. It can become so extreme that the individual avoids the responsibility of being a spouse, parent, friend, or employee (Nayback, 2009).

Roy's Adaptation Model stresses the importance of avoiding PTSD or developing coping strategies to avoid the symptoms. Coping is defined as "innate or acquired ways of interacting

with the changing environment" (Nayback, 2012, pg 306). Roy classifies individual coping processes in two ways; innate coping (genetically determined and automatic) and acquired (learned strategies for managing stimuli) (Nayback, 2012). There are also two individual coping dimensions; regulator coping subsystem (automatic neural, chemical, and endocrine response to stress) and cognator coping subsystem (cognitive-emotional coping comprising of judgment, perceptual and information processing, learning, and emotion) (Nayback, 2012). The numerous physiological and physical effects can be damaging both in the present and long term.

The reason this framework was chosen is because it shows how this type of stress (PTSD) can have significant effects on the body if not recognized early on and treated. Roy's Adaptation Model also gives a better understanding about PTSD in the post deployment population. It also highlights how treatment can be beneficial to help cope with or decrease the symptoms of PTSD by adapting to the environment both externally and internally. Roy's Adaptation Model will be incorporated into the PowerPoint presentation so the health care staff can understand PTSD and the detrimental effects of PTSD when the military member is not able to adapt to their environment.

Process

PTSD research is abundant. The information on the Internet covers all aspects of the disease including, signs/symptoms, long-term effects, numerous treatments, and the success of treatments. There is also research on how to prevent PTSD using coping techniques when faced with a stressful situation.

Reviewing the literature for this project included searching the internet for treatment options for PTSD and their success, the signs and symptoms associated with those diagnosed

with PTSD, the detrimental effects of the disease at a progressive state, and what procedures are in place to help post deployment military members. The search engines used were Google scholar, the University of North Dakota (UND) libraries database, and Bing scholar. The two engines, Google and Bing, were helpful in finding articles and the library database allowed access to the articles, as most of them were not accessible without paying for access.

The main issue with the review of the research was the lack of the research on the military and their treatment of PTSD. Part of the reason may be that until recently, with the numerous deployments of military members, it has become a significant issue. Another reason may be that the research is limited due to the stigma that surrounds mental illness; as well as military personnel not having to report PTSD symptoms until just recently. Since it stigma of reporting PTSD symptoms has been addressed more military personal suffering from those symptoms are coming forward to receive help. However, even though more are continuing to seek help, there is still a significant number who do not seek help, which is why this subject was chosen as the project. No research was found regarding the requirement for military members to attend mandatory counseling after a deployment.

Review of Literature

There are several treatment therapies for PTSD. A review was conducted on three types of treatment; therapy (counseling), medication therapy (specifically Prazosin), and Yoga. Five research articles were reviewed for each treatment therapy.

Therapy/counseling has been shown to be effective in the reduction of PTSD symptoms. In a study published by the Journal of Anxiety Disorders, an open trial was conducted on 37 male Veterans (ages 40-72) with combat-related nightmares and they were exposed to Imagery

Rescripting and Exposure Therapy (IRET). This study found a "reduction in frequency of nightmares (from 4.8/week to 2.4/week), improved sleep (4.0 h/night to 5.4 h/night), and decreased PTSD frequency to a degree that is both statically significant and clinically meaningful" (Long et al., 2011. pg 534). Imagery Rescripting gives the patient power to change their reoccurring dream by reading a less traumatic version of the dream, written by the patient, right before going to sleep for the night. The participants were enrolled in a six-week multi-component group intervention in which the sessions included: psychoeducation related to the treatment and the connection between the traumatic event (s) and the nightmares, practicing relaxation techniques, psychoeducation on the impact of insomnia on cognitive-behavioral skills, review of exposure rationale and exposure to the original nightmare, review of rationale for imagery rescripting and modification of the original nightmare, review of skills, relapse preventing planning, and application of skills to future possible nightmares. A limitation found with this study is it only addressed one symptom in a long list experienced with PTSD. The participants were also chosen by referral from their mental health provider so it was not a randomized study. Another significant finding is that these men were older and their exposure to combat was related to World War II, Vietnam, and Desert Storm. The gap in knowledge in using this therapy on the younger generation of war veterans warrants continued research.

A study published in Depression and Anxiety, 20 war veterans with a mean age of 60 were treated for their PTSD symptoms using Mindfulness-based Cognitive Therapy (MBCT). This study also found a significant decrease in PTSD symptoms (King et al., 2013). The study was conducted over an eight week period and the sessions included: mindful techniques, psychoeducation regarding PTSD and stress response, feedback and supportive group discussion of exercises, mindfulness exercises such as; mindful eating, mindful stretching, and 3-minute

Breathing Space. They also were required to practice the techniques at home. Limitations of this study were three-fold: 1) participants were referred by their mental health provider so it was not a random study; 2) the study participants had a mean age of 60 again indicating this therapy had not been tested on the younger generation, whether it be veterans or active duty personnel; and 3) the study was a small sample (20). Recommendations for replicating this study could be a larger and randomized sample should be researched. Since this therapy proved to be successful in the reduction of PTSD symptoms further research should be conducted on the younger war veteran.

In 2007, the Journal of the American Medical Association did a study specifically on 141 women who were post war veterans and currently serving active duty. This study used Prolonged Exposure Therapy and 41% of participants experienced relief of symptoms and no longer meet the criteria to be diagnosed with PTSD. The participants participated in a 10 weekly 90 minute sessions in which the participants were educated about common reactions to trauma, breathing training, repeated recounting of trauma memories, homework (included listening to recording of the recounting made during the therapy session and repeated in vivo exposure to safe situations the patient avoids because of trauma-related fear), and discussion of thoughts and feelings related to exposure exercises (Schurr et al., 2007). This study only focused on women resulting in a significant gap in knowledge of male military personnel. Randomization did not occur; the participants were referred from their mental health provider. A significant finding in this study is not only did these women experience combat trauma, but some also experienced military-related sexual assault. The significant elimination of all PTSD symptoms because of this therapy warrants future research to include a larger randomized sample to include men and women.

Upon review of the literature presented above, the type of therapy was not indicated between group or individual therapy. A natural assumption is that the type of therapy found in

the articles was individual. As mentioned previously, group therapy can be very therapeutic to those suffering from PTSD, due to the validation and understanding with others sharing the same experiences.

Psychological Trauma, Theory, Research, Practice, and Policy published a study in 2013 in which 20 male combat veterans (27-69 years) participated in group-based exposure therapy (GBET). Eighty-five percent of the participants experienced reliable reduction in their symptoms. (Mott et al., 2013). Participants were involved in a three hr. session, which meet bi-weekly for 12 weeks. The sessions included psychoeducation and group-building exercises, focuses on exposure to trauma memories and triggers, focuses on acceptance and closure through visual imagery and discussion of grief and guilt. After participants discussed their traumatic events, the therapists as well as the other participants offered supportive feedback. The participants also had exposure to events that may trigger their symptoms (waiting in line at a crowded store or watching a war movie) at least 4-5 times per week. The significant finding of this study was that the participants stated the best part of the therapy was the feedback received from the other participants. This group therapy incorporated exposure therapy but also added an element that has not been seen in the other studies. Again this study's participants were also not randomized as they were referred from the participant's mental health provider. The age range is better with this study but did not include the female population. The results of this study are significant and warrant further studies with a larger, randomized sample to include the female population.

The last study review on therapy/counseling was published by The Journal of Clinical Psychiatry in which 125 males diagnosed with PTSD participated in anger management therapy either in person or via teleconference. The study showed a significant and clinically meaningful

reduction in anger symptoms. The participants engaged in anger management therapy (AMT), which was two sessions a week for a six-week period. During these sessions participants learned how to "monitor their anger using the "anger meter" and to identify the specific cues and triggers to their anger, develop cognitive and behavioral coping strategies for controlling their anger and consolidate these strategies into a specific individualized control plan, examine the relationship between anger and violence, and learn the ways anger is used to cover up emotions" (Morland et al., 2010, pg 858). The significance of this study was it showed it is possible to branch out through the computer to help those who are unable to attend sessions in person. The study was randomized in the matter that the participants did not know if they would be attending the sessions in person or on the computer. The participants, however, were not randomized in that they were referred to the study from their mental health providers. The study didn't include women because there were not enough diagnosed with combat PTSD.

Medication therapy is an option for treatment of PTSD. The most significant symptoms experienced by PTSD sufferers are nightmares, insomnia, and loss of Rapid Eye Movement (REM) sleep (Shad, Suris, & North, 2011). Treatments with medications normally include selective serotonin reuptake inhibitors (SSRIs), however, this medication has yielded unsatisfying remission rates of only 23-51% over 3-6 months (Shad et al., 2011). Prazosin, an alpha-1-adrenergic receptor blocker has been recently recommended and is showing promising results in the resolution of nightmares and insomnia.

A study published in the American Journal of Health-System Pharmacy concluded the use of a placebo and elevating doses up to 15 mg of Prazosin over 28 days. The group only receiving Prazosin resulted in decreases in nightmares by fifty percent (Taylor, Freeman, & Cates, 2008). A significant finding was the adverse effects experienced as four out of the forty

patients stopped taking the drug because of dizziness. This study was conducted on PTSD patients from combat exposure and 34 patients were already in therapy but continued to have nightmares. This study also only had two women and a very small sample size. The study did not disclose how these patients came to be in the study but it is assumed they were referred from a mental health care provider. The results are significant enough that more research needs to be conducted with this drug and a larger sample size to include more women.

The American Journal of Psychiatry conducted a study using Prazosin and a placebo for nightmares, sleep quality, and global status to sixty-seven soldiers to include an unknown number of women. The patients receiving the placebo were the control group and the patients receiving Prazosin were the experimental group. The patients were recruited for the study by advertisement through fliers and banners, and mental health care providers referred others. The study did not disclose how many patients were self-referred or referred by providers. The inclusion criteria included the patient had to experience nightmares at least two days a week and a diagnosis of PTSD. The study was conducted over fifteen weeks and the drug was titrated to effect based on response to nightmares over six weeks. During the 7th week, 11 patients dropped out of the study, which left forty-six who completed the study. This randomized study is the first known study conducted on active duty U.S. combat service members. At the end of the study, there was a significant decrease in nightmares, better sleep quality and global status (Raskind et al., 2013). The study also concluded that despite the effectiveness of Prazosin, the majority of the U.S. military members still continued to experience PTSD symptoms. The authors recommend combined therapy with drug use to alleviate PTSD symptoms. A problem with this study is the sample size and it is also not known if the patients were also receiving one on one therapy with

their therapists, although it is assumed they were. The result of decreased nightmares is significant and this warrants further studies of this drug.

U.S. military members often face multiple deployments, which can compound PTSD symptoms. A study published by the Journal of Traumatic Stress revealed military members often have nightmares while in a deployed setting, not just while back at home. Thirteen soldiers deployed in support of Operation Iraqi Freedom were given Prazosin while in Iraq because they reported persistent and distressing nightmares, affecting their combat missions. Results were significant; a) nightmares decreased by fifty percent, b) night waking decreased, c) difficulty falling asleep decreased, d) increased sense of well-being (Calohan, Peterson, Peskind, & Raskind, 2010). Of the thirteen in the study, only one experienced adverse effects (nausea and headache). This is the first study to be conducted on military members who were on a current deployment. The study also followed two of the members post deployment and both members reported no nightmares five months after returning home (Calohan et al., 2010). These findings are significant because there is successful use of therapy while on a deployment and while the traumatic events are occurring. The findings of this study are significant but limited as the sample size was small. Research in this area should be continued with a larger sample size and increased numbers in both genders.

The Journal of Psychopharmacology published a study in 2010 comparing two medications and which medication patients continued over long term therapy. The medications studied were Prazosin and Quetiapine. Quetiapine is an anti-psychotic but also exerts alpha-1-adrenergic blocking activity. The study included a review of 237 patient records; sixty-two had received Prazosin. Short-term effects were similar as both groups had a significant decrease in nightmares within a six-month period (Byers, Allison, Wndel, & Lee, 2010). A significant

finding is forty-four patients who were initially prescribed Quetiapine were changed to Prazosin because of the adverse effects of the Quetiapine (hypotension, dizziness, sedation, metabolic effects,) (Byers et al., 2010). A significant finding was of the patients taking Prazosin; forty seven percent continued taking the drug over the next six years. Prazosin is the drug of choice for long-term therapy of nightmares related to PTSD. The study, however, only looked at records between 2002 and 2005 and the mean age of the participants was fifty- four, indicating they were Vietnam or Gulf War veterans and not currently active-duty. Further research should be conducted on records within the last five years to evaluate this medication use on active duty members for long-term use.

The final study reviewed evaluates the use of Prazosin versus cognitive behavior therapy (CBT). A randomized controlled trial conducted by the Journal of Psychosomatic Research on 144 patients found a sixty one percent improvement in sleep with Prazosin and CBT over the placebo group. Another significant finding is with the combined therapy there was a reduction in daytime PTSD symptoms (Germain et al., 2012). This study recruited patients over a four-year period by television, radio, and newspaper advertisements, resulting in over 1500 applicants. A significant problem with this study is sixty five percent of the veterans who were recruited were excluded and the study does not represent the majority of veterans with PTSD nightmares. The study also did not clarify how many of the participants were female, just pointing out that ninety five percent were male (Germain et al., 2012). The results, however, are significant because the participants were random and not referred from a mental health care provider. Further research in warranted to test combined therapy of CBT and Prazosin.

The final therapy option reviewed is Yoga. "Yoga, which incorporates both breath work and movement, is becoming increasingly recognized as an effective treatment modality for

reducing symptoms of PTSD" (Stoller, Greuel, Cimini, Fowler, & Koomar, 2012, pg. 60). The American Journal of Occupational Therapy conducted a study on seventy military members currently deployed to Iraq; thirty-five members engaged in hatha yoga classes for three weeks and were required to attend at least two sessions per week, while thirty-five did not participate in any yoga classes. The sample was random and consisted of fourteen women and twenty-one men. After completing the program, the participants experienced reduced anxiety and hyper-arousal (Stoller et al., 2012). The limitations of this study included; a) confirmed diagnosis of PTSD, b) sample size, and c) duration of the study. The findings are significant and further research is warranted.

In 2013, Military Medicine published a study on twelve PTSD military members and their success with yoga therapy. After participating in yoga twice a week for six weeks, military members reported a decrease in hyper arousal symptoms and overall improved sleep quality (Staples, Hamilton, & Uddo, 2013). Participants were recruited by referral from PTSD Clinical Team clinicians. There were ten males and two females who had been diagnosed with PTSD by a mental health provider. The yoga sessions used a therapeutic approach in which yoga movements were linked to breathing with meditation; this combination promotes calmness and a sense of control. A significant finding with this study is the participants did experience improvements with anger management or quality of life. It is recommended that this therapy be incorporated with other therapies (counseling) to see decreased symptoms overall. Limitations with this study included; a) sample size, b) gender size, c) length of study, and d) age of participants as most were from the Vietnam serving era. The significance of the decrease in PTSD symptoms warrants further research on this therapy.

The first two studies focused primarily on men. In a study published by Journal of Traumatic Stress, thirty-eight women diagnosed with PTSD participated in a randomized controlled trial in which they either participated in bi-weekly yoga sessions for six weeks or attended group sessions once a week. All participants filled out questionnaires for twelve weeks. Both groups experienced a reduction in PTSD symptoms equally. The significant symptoms experienced were decreased hyper arousal and decreased reliving the event. The yoga sessions also involved body movements and breathing techniques for stress reduction and calmness (Mitchell et al., 2014). The participants were recruited by filers and ads in local newspapers, as well as online media sources (Craigslist). The participants were war veterans as well as civilians with traumatic experiences diagnosed with PTSD. The authors felt both therapies were beneficial for reduction of symptoms. The authors also stated that the reason the group sessions were helpful was because each time the participants had to attend a session in which they answered a questionnaire, they were reminded about their symptoms and the reminder made them learn how to cope. A limitation with this study was the authors did not disclose how many military veterans were in the study and which method they participated in. The participants were also paid for each session, which could decrease the validity of the responses to treatment. The results of the study are significant enough that further research should be conducted.

The Journal of Clinical Psychology published a study in 2012 in which the concept of mindfulness-based stress reduction (MBSR) was introduced. MBSR is a form of yoga in which an instructor leads the group in a guided exercise while the participant is lying down with their eyes closed. During this exercise, participates bring attention to their body awareness and bring non-judgmental awareness to passing thoughts and emotions (Kearney, McDermott, Malte, Martinez, & Simpson, 2012). Breathing exercises were incorporated into the exercise to increase

calmness. Ninety-Two veterans participated in the study over a seventeen-month period. All of the participants were referred by mental healthcare providers and were already receiving another type of therapy. The participants attended bi-weekly, two and a half hour MBSR sessions for eight weeks and then had follow-up assessments at two months, four months, and 6 months. Seventy-two percent of the participants completed the entire process. Forty-seven percent of the participants saw a decrease in their PTSD symptoms (Kearny et al., 2012). Limitations of this study include; a) participants were veterans but it's unknown how they acquired PTSD diagnosis, b) sample size, c) conjunctive therapy (medications, counseling), and d) therapy not specific to PTSD symptoms.

The final study on yoga therapy combined yoga and group therapy on veterans who had been suffering from PTSD symptoms for numerous years. The study, published by the Journal of Traumatic Stress Disorders & Treatment, involved fourteen male Vietnam veterans who participated in twenty two hours of guided group yoga over five days followed by two-hour group sessions weekly for the first month and monthly thereafter for five months (Carter et al., 2013). Another eleven participates (control group) were not exposed to yoga or therapy and they were evaluated after six weeks regarding their symptoms. After six weeks, the control group had zero decrease in symptoms so they were offered the treatment (Carter et al., 2013). At the six-week evaluation for the intervention group there was a significant decrease on PTSD symptoms and at six months for both groups there was an even greater decrease in symptoms. This is significant because the participants had been receiving therapy for numerous years without changes in symptoms. These participants initially did not receive any type of therapy for the disorder when first diagnosed. This study proves that early intervention for military members returning from war is vital so veterans are not suffering from a debilitating disease for numerous

years. Limitations for this study include sample size and gender. The study also revealed at the end that the participants were all Australian Vietnam veterans. The results of this study are significant enough to warrant further studies involving a more diverse, larger sample size.

Outcome/Dissemination

After the review of literature was complete, the deliverable portion of this independent project was to conduct a PowerPoint presentation addressing PTSD to the healthcare staff of the 78th Medical Group. The presentation included signs/symptoms of PTSD and the detrimental effects the disease can have on not only the military members but also on their families, loved ones, and friends. It also presented research-based evidence of early counseling effects on reduction or elimination of the symptoms. The presentation also educated the participants on other treatment options and the success associated with those treatment options in decreasing or eliminating symptoms. These treatments include counseling (cognitive behavior therapy, group, and family), medications, and yoga.

Interpretation

The presentation was well received by the 78th Medical Group staff. They were unaware of the how serious this issue is and expressed concern about what the next will be to implement mandatory counseling to our members returning from deployment. With the current operation tempo in the medical group, the psychologists, social workers, and mental health nurse practitioners are overloaded with patients being seen for other issues. The idea was mentioned that a PowerPoint presentation could be incorporated into the inprocessing briefing given to returning deployers. They all agreed not enough is being done to help out military members as far as changing the culture about the stigma attached to being seen by mental health for PTSD

symptoms and making appointments available to them. They agreed to be sure to be more proactive with patients and be aware of the signs and symptoms of PTSD. One of the staff members mentioned that if they counseling was mandatory, more suicidal members could be caught and treated. Too many lives have been lost to suicide because of PTSD symptoms. The staff also stressed they will not overlook symptoms because the patient states they are "ok".

The goal of this presentation was to make the staff at the 78th Medical Group aware of the issue of the severity of PTSD and the treatment options available. The presentation also stressed how important it is for a military members to receive help for their symptoms. It will take numerous endorsements to make counseling mandatory for military members returning from deployment, but if there can be change at the 78th Medical Group by way of a PowerPoint presentation for returning deployers then that is a big step in the right direction.

Implications

There are no safety nets in place for post deployment military members for evaluation of PTSD symptoms. A through assessment of a post deployment military member is critical in order to identify any symptoms of PTSD. Early recognition and treatment is proven to be successful in reducing or eliminating symptoms. Evaluation of any comorbid risks; alcohol or drug use, should also be considered as well as including questions regarding suicide intentions. Although PTSD and suicidal ideations can be a delicate and difficult subject to talk about, as healthcare providers we are required to ask these questions when signs or symptoms of PTSD are noted. After recognition of any signs or symptoms, the member should be encouraged to seek help. In order for the member to seek help for psychological needs, the culture must be changed

so that the stigma for seeking care in minimalized and seeking assistance is rewarded (Hagerty, Williams, Bingham, & Richard, 2011).

Education

This topic will impact the nursing field in being able to understand our PTSD patients and encourage treatment. As nurses we need to treat the patient holistically and the signs or symptoms of PTSD can be subjective. We also need to treat the family members affected by PTSD. Knowing the signs and symptoms and treatment options can assist nurses in providing education for the families. There may be a family member that approaches the nurse about certain signs that are concerning. Quick recognition means quick treatment for the patient. As a nurse educator, it will be a priority to educate all nurses on this disease. This is not just a topic that should be addressed by mental health care providers. Nurses should be available to their patients regardless of their chief complaint. A patient's interaction with a nurse might be that one time the patient with PTSD feels comfortable and they finally open up to tell their story. Nurses also need education on dissolving the stigma associated with mental illness and receiving mental health care. Nurses need to reserve judgment on those diagnosed with PTSD and respect the fact that it is a real disease and can be devastating to the patient.

Research

Research needs to continue with evaluating treatment options for post-deployed military members, especially group therapy. Some suggestions to assist post-deployed military members reach an optimal level of functioning once diagnosed with PTSD could be: 1) conduct a pilot study on post-deployed military members involvement in group counseling, with a survey given at the end of the counseling session; 2) mandating that all returning military members must

attend at least one session of group therapy; and 3) reassurance to the military members that there is no repercussions for participating in treatment.

Further research should also be conducted on all treatments available and if mandatory counseling is not warranted after several studies, then alternative mandatory treatments should be studied. Alternative treatments could include yoga, acupuncture, or research could also be conducted on which alternative the military member would prefer if it were deemed mandatory. With over 120,000 post deployment military members diagnosed with PTSD as of March 2014, more research on immediate treatment after returning needs to be conducted (Defense Centers for Excellence, 2014).

Practice

The author's clinical practice will change to reflect support of mandatory counseling for military members after their deployments. If a patient is post deployment, questions regarding attendance at a counseling session. The goal is to expand the presentation to include the medical group staff and eventually present it to the Air Staff level or higher Air Force. Educating staff regarding PTSD symptoms and the detrimental side effects if not treated is the first step in the process.

As the project progresses, more issues about PTSD are seen in the media. The most recent event occurred at Ft Hood in which a military member shot and killed three people and injured numerous others. There is uncertainty regarding the shooters military medical record as to whether or not he had PTSD. He did exhibit signs of having the disease and was seeking help. He deployed in 2011 for four months to Iraq but did not see combat. Any traumatic event can cause PTSD, not just combat. Leaving his family to be deployed to an austere location could

have been enough to trigger symptoms. This reaffirms the need for more to be done for military members after deployment.

Implementing mandatory counseling will be challenging as it will require many hours of convincing many bureaucratic divisions. Starting small and making an impact on the intended target; coworkers and post deployment military members, could be the push needed for upper level management support. The process has begun at the 78th Medical Group by educating medical staff on the detrimental effects of PTSD to military members who have deployed The goal is that with the support from the medical staff; as well as advocacy, there may be a change.

Summary

Upon completion of this project, it was identified that a mandatory briefing on PTSD given to post-deployed military members may also be beneficial. A presentation on the signs and symptoms of PTSD, the effects of the disease is left untreated, and treatment options available could be presented. Often times, military members are unaware of the signs and symptoms as they often just mistake them as normal responses to a traumatic event (Clark-Hitt, Smith, & Broderick, 2012). The briefing also should include what types of interventions are done during counseling. These might include; teaching about trauma and its effects, how to use relaxation and anger control skills, provide tips for better sleep, diet, and exercise habits, help identify and deal with guilt, shame, and other feelings about the event, and focus on how people react to their PTSD symptoms (National Institute of Mental Health. N.D.).

PTSD can be a debilitating disease, which can have detrimental health effects. It can cause anger outbursts, nightmares, difficulty sleeping, avoidance of family and friends, depression, and self-destructive behaviors. Left untreated, the person can have these signs and

symptoms the rest of their lives. Far too many people have lived with this disease and felt their only outlet was suicide. Jacob Hutchson, a 24 y/o Iowa National Guard medic, was critically wounded in 2011 while serving in Afghanistan. Even though his injuries were debilitating, he wanted to be a nurse and planned to attend nursing school this fall. When he returned home after his rehab for 19 months, he told his mother he was not the same person and she notice he was different and showed some signs of PTSD. She stated he was still an upbeat person and looked forward to the future. Jacob had recently made an appointment to see a counselor for his anger issues. April 24, 2014, Jacob killed himself. Jacob slipped through the cracks. How many more military members are we going to lose before the military makes counseling mandatory?

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POST TRAUMATIC STRESS DISORDER

Christine Ainsworth, BSN

Overview

- What is PTSD?
- Signs/Symptoms
- Framework
- Treatment options for PTSD
- Evidence of treatment success
- Current process for post deployment military members
- Why mandatory counseling?
- What you can do...

What is PTSD?

Post-traumatic Stress Disorder (PTSD)

- A severe anxiety disorder that develops after a terrifying ordeal that involved physical harm or the threat of physical harm.
- Can also be brought on by the physical harm or threat of physical harm to loved ones or strangers (Harmon, S.C., Hoyt, T.V., Jones, M.D., Etherage, J.R., & Okiishi, J.C. 2012).

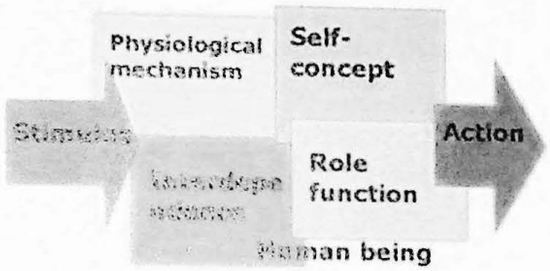
Signs/Symptoms

- Flashbacks of events
- Nightmares
- Difficulty sleeping
- Avoidance of social situations
- Feeling numb
- Guilt
- Depression
- Easily startled
- Feeling tense
- Angry outbursts
- Self-destructive behaviors
- Constantly on guard (Shen, Y., Arkes, J., Kwan, B.W., Tan, L.Y., & Williams, T.V. 2010)

Roy's Adaptation Model

Sister Callista Roy developed a model which focuses on the individual's adaptation to their changing environment. Coping strategies are essential to adapt to the internal and external stimulus.

Four Adaptive Models/Modes- Each mode is significant when adapting to the environment or stimulus.



Roy's Adaptation Model

Physiological Mode-

- The body reacts to PTSD by reducing plasma beta-endorphin concentrations which results in a decreased pain threshold.
- The body will overreact to stress and have an increased anxiety

Self-Concept Mode-

- PTSD decreases the feeling of being in control and feeling of being safe
- This belief can result in health deterioration physically, emotionally, and socially

Roy's Adaptation Model

Role-Function Mode-

- PTSD can make it difficult for military members to assume their role in society especially in the immediate family
- This can lead to distancing themselves from family or friends

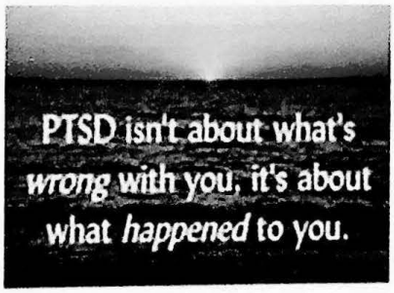
Interdependence Mode-

- PTSD can make military members emotionally numb and unable to show emotions to family or friends
- This can result in the military members withdrawing from friends and family and not be able to function in their role as spouse, friend or parent (Abu Shosha, G., & Al Kalaldeh, M., 2012)

Treatment Options

Counseling

- Group
- Family
- Individual



Medications

Yoga

Evidence of Treatment Success

Counseling (group, family, and individual)

- Several studies were reviewed and all found a significant decrease in PTSD symptoms with the use of counseling.
- Group counseling was the most effective with military members as they were able to relate to each other and their feelings were validated and understood by others with similar experiences.
- All of the studies included counseling on how to develop coping mechanisms which are essential to adapting to the environment (Hayback, 2009).

Evidence of Treatment Success

Medications

- Several medications are used in the treatment of PTSD symptoms, specifically nightmares. These include: a) anti-psycotics, b) selective seratonin re-uptake inhibitors (SSRIs), c) anti-hypertensives, and d) alpha-1-adrenergic receptor blockers.
- Prasozin (alpha-1-adrenergic receptor blocker) was researched in five studies and found to have a significant effect on decreasing nightmares.
- The only side effect experienced with this medication is dizziness reported in one study (Taylor, H.R., Freeman, M.K., & Cates, M.E., 2008).

Evidence of Treatment Success

Yoga

- Five studies on the effect of yoga on PTSD showed promising results on decreasing hyper arousal.
- Yoga is versatile and in one study, this therapy was able to be used while downrange because it is easily accessable and there are no side effects (Stoller, C.C., Greuel, J.H., Cimini, L.S., Fowler, M.S., & Koomar, J.A., 2012).
- Members can also participate in yoga classes without the added stigma of seeking mental health care.

Current Process for Post Deployment Military Members

Post Deployment Health Risk Assessment (PDHRA)

- Questionnaire
- Face to Face appointment
- Done on arrival home, at 90/120/365 days post deployment
- Referred to mental health upon request of military member only
- Positive indicators of PTSD DO NOT result an appointment generated with mental health

Why Mandatory Counseling?

Why Mandatory Counseling?

https://www.youtube.com/watch?v=3irRPObFW8s

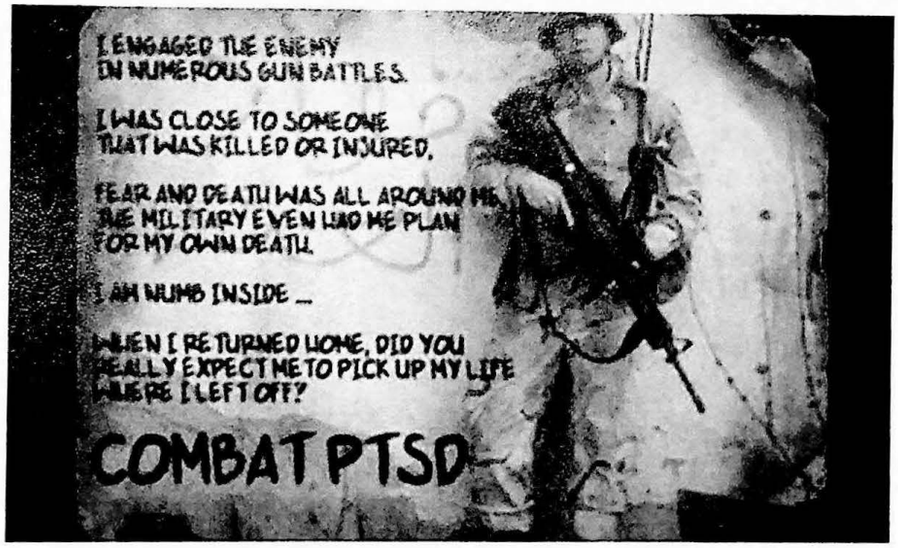
- Military members should be given the tools necessary to cope with PTSD. We give them the tools necessary for deployment and mandate they are used.

- Upon return from deployment, we should mandate they receive counseling which will give them the tools they need to cope.

What you can do....

- Familiarize yourself and your staff on the signs/symptoms of PTSD
- Encourage members to seek help for any PTSD symptoms, mild or severe
- Advocate for mandatory counseling for returning members
- Speak with members regarding seeking alternative therapies if unable to convince them to seek counseling
- Be vigilant with recognizing signs/symptoms of PTSD and don't be afraid to ask questions... you could save a life.

PTSD



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