



## **PTSD in Afghanistan and Iraq War Veterans**

*Reprinted from Sonoma Medicine magazine. Dr. Keram is a staff psychiatrist at the VA Outpatient Clinic in Santa Rosa.*

IN 1996, AS PART OF A NATIONWIDE EFFORT to make health care more accessible to veterans, the San Francisco VA Medical Center established its first outpatient satellite, the Santa Rosa Community Based Outpatient Clinic (CBOC). Ten years later, the Santa Rosa CBOC provides primary care and mental health treatment to over 5,000 veterans. With the ongoing wars in Iraq and Afghanistan, Santa Rosa CBOC clinicians, along with counselors at the Vet Center in Rohnert Park, are currently treating veterans with very recent combat experience.

The Department of Defense (DoD) refers to the wars in Afghanistan and Iraq as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), respectively. CBOC and Vet Center patients now include OEF/OIF veterans from all branches of the armed forces, as well as Reservists and members of the California National Guard.

Upon return to the United States, all OEF/OIF veterans-whether they served in the regular armed forces, the Reserves, or the National Guard-are entitled to a two-year period of free care through the VA. The VA encourages these veterans to file a claim for service-connection for appropriate diagnoses during that two-year period, to ensure that all service-related conditions are recognized and compensated. Once a veteran's claim is accepted, the VA provides life-long free care for all service-connected diagnoses. As veterans of previous wars will attest, the longer a veteran waits to file a claim, the more likely the difficulty in locating supporting military and medical documentation, thus delaying the claim's adjudication. These potential delays make early recognition of service-related illness especially important.

Although the DoD and the VA provide OEF/OIF veterans with contact information for local VA services, these veterans may also access other providers of care. The DoD is relying on members of the National Guard and Reserves in the current conflicts, so many military returnees are older, resuming previous employment, and privately insured. They may prefer to turn to long-standing relationships with their community primary care physicians for help with postdeployment medical and mental health issues. Their mental health concerns may affect other health issues seen in the primary care setting.

All veterans, including OEF/OIF veterans, are administered a postdeployment health assessment on their return from active duty. National assessments completed between May 1, 2003, and April 30, 2004, demonstrate a prevalence of reporting a mental health problem of 19.1% among Iraq veterans and 11.3% among Afghanistan veterans, compared to a prevalence of 8.5% among veterans returning from other locations.<sup>1</sup> Thirty-five percent of Iraq war veterans accessed mental health services in the year after returning home; 12% per year were diagnosed with a mental health problem.<sup>1</sup>

Combat exposure is the war-zone stressor most commonly associated with mental health symptoms in postdeployment veterans. However, OEF/OIF veterans may have been exposed to additional stressful or traumatizing issues and events, including difficult living and working environment; concerns about life and family disruptions; sexual or racial harassment; perceived exposure to radiological, biological, and chemical weapons;

perceived threats, insufficient preparedness, and inadequate armaments; exposure to suffering of servicemen and civilians; and exposure to death and destruction.<sup>2</sup> OEF/OIF veterans are at risk for developing depression, substance use disorders, and PTSD.

Symptoms of PTSD include re-experiencing trauma (nightmares, intrusion, flashbacks), avoidance of reminders of trauma, emotional numbing and detachment (lack of intimate relationships, sense of foreshortened future), and autonomic arousal (anxiety, insomnia, cognitive difficulties, exaggerated startle reflex, and hypervigilance).<sup>3</sup> Depression, guilt, shame, and panic attacks may also be present.

The Iraq War Physician Guide reports that over 90% of veterans indicate that their traumatic experiences and symptoms are important and relevant to their primary care.<sup>2</sup> The relationship between trauma exposure and increased health care utilization appears to be mediated by the diagnosis of PTSD. Primary care physicians are accustomed to evaluating and treating patients for common mental health concerns, including depression, bereavement, and substance abuse. Screening for PTSD may be done in the primary care setting as well (see box). Endorsement of any three items on the Primary Care PTSD screen is associated with a diagnostic accuracy of 0.85 (sensitivity 0.78, specificity 0.87) and indicates the need for further evaluation.

Primary care physicians can serve important functions for returning OEF/OIF veterans with PTSD. Physicians should acknowledge their patients' difficulties with statements such as, "I am so sorry that you are struggling with this," and "I can appreciate how difficult this is for you." Patients with PTSD may be worried that their symptoms are a sign of weakness or that they are "going crazy." They should be reassured that their symptoms are a common and expected reaction to extraordinary stress.

Some patients find it helpful to identify symptoms such as hypervigilance and insomnia as behaviors that helped them quickly identify and respond to danger while on active duty. Thus, although they are maladaptive in the civilian setting, some symptoms of PTSD are actually protective in combat. Patients should also be reassured that treatment exists for PTSD, and that both medication and therapy are available that will ameliorate its symptoms. Disability, should it occur, is likely to be temporary.

In addition to providing reassurance and treatment to patients, primary care physicians can provide them with educational resources, so that they and their families can learn more about living with PTSD. Particularly useful is *Courage After Fire: Coping Strategies for Troops Returning from Iraq and Afghanistan and Their Families*.<sup>4</sup> Written by clinicians in the PTSD Program at the San Francisco VA Medical Center, this book reviews common reactions to war and coping strategies, and it provides information about additional resources. The VA's National Center for PTSD also maintains a website with educational handouts for veterans and their families; the address is <http://www.ncptsd.va.gov/>.

Community physicians should encourage veterans to file claims with the VA for diagnoses they believe are related to their military service. Veterans should be referred to the Sonoma County Veterans Service Office (707-565-5960), where an officer will help them file claims and obtain other federal benefits to which veterans and their family members are entitled.

A diagnosis of PTSD has implications for the patient's physical health as well. PTSD is associated with an increased risk of alcohol and drug abuse and risky sexual behavior. PTSD can also lead to neurobiological dysregulation, altering the functioning of the catecholamine, hypothalamic-pituitary-adrenocorticoid, endogenous opioid, thyroid, immune, and neurotransmitter systems. In addition, exposure to traumatic stress is associated with increased health complaints, health service utilization, morbidity, and mortality.<sup>2</sup> Finally, appointments with primary care physicians may be anxiety-provoking and trigger symptoms of PTSD. Physicians should be ready to respond to such scenarios (see box).

The VA specializes in the pharmacological and psychotherapeutic treatment of service-

related PTSD. However, some veterans may prefer to receive treatment in the community. Although referral to the VA is recommended in almost all cases, some patients with mild symptoms may be prescribed medication in the primary care setting. Medication as a stand-alone approach to treatment is not recommended, however, so referral to the VA for psychotherapy should be made as well.

SSRIs are generally used as the first-line medication for PTSD. In addition to diminishing the re-experiencing of symptoms and autonomic arousal, SSRIs are useful for comorbid symptoms such as depression and panic attacks. Sedative-hypnotics are usually avoided, as insomnia may become a chronic feature of the diagnosis. Patients with sleep disorders often respond well to trazodone or diphenhydramine. Recently, prazosin has been demonstrated to be effective at reducing or eliminating traumatic nightmares, with subsequent improvement in length and quality of sleep. Atypical antipsychotics may be useful as augmentation strategies for patients with treatment-resistant insomnia, severe anxiety, agitation, paranoia, hypervigilance, and dissociation. Anticonvulsants may be helpful for patients with aggression and impulsive behavior.<sup>2,5</sup>

The current conflicts in Iraq and Afghanistan may reactivate or exacerbate PTSD symptoms in veterans of earlier armed conflicts. Exposure to news of the war, along with real or perceived similarities between the current conflicts and previous wars, may cause veterans to experience intrusive thoughts, memories, and images of their combat experiences. These symptoms, along with nightmares, emotional numbing, and autonomic arousal may cause disruption in family, social, and occupational functioning. Therefore, it may be useful for primary care and other physicians to ask their veteran patients whether the current conflicts are causing them stress and symptoms. Re-traumatized veterans should be reassured that their reactions are expected, normal, and amenable to treatment, should they so desire.

To summarize, treatment of OEF/OIF veterans presents new challenges to physicians. Due to the increased role of the Reserves and National Guard in Afghanistan and Iraq, and because many Reserve and Guard veterans have private insurance, community-based physicians will likely treat veterans with recent combat experience. Developing an increased expertise in the diagnosis and treatment of PTSD, as well as an awareness of the resources available to OEF/OIF veterans and their families, will improve medical and mental health care for these special men and women.

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2. National Center for Post-Traumatic Stress Disorder, *Iraq War Physician Guide*, 2nd ed., <http://www.ncptsd.va.gov/> (June 2004).
3. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., American Psychiatric Publishing (2000).
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