Patient Management Exercise

Posttraumatic Stress Disorder

Terence M. Keane, Ph.D.

This exercise is designed to test your comprehension of material presented in this issue of *FOCUS* as well as your ability to evaluate, diagnose, and manage clinical problems. Answer the questions below, to the best of your ability, on the information provided, making your decisions as you would with a real-life patient. Questions are presented at "decision points" that follow a section that gives information about the case. One or more choices may be correct for each question; make your choices on the basis of your clinical knowledge and the history provided. Read all of the options for each question before making any selections. You are given points on a graded scale for the best possible answer(s), and points are deducted for answers that would result in a poor outcome or delay your arriving at the right answer. Answers that have little or no impact receive zero points. At the end of the exercise, you will add up your points to obtain a total score.

Case vignette part 1: presentation to clinic for returning veterans

David is a 32-year-old married Caucasian male seeking psychiatric help following the loss of his job and stressors in his marriage. He was referred to VA mental health services by an employment counselor who identified him as a veteran of the wars in Afghanistan (Operation Enduring Freedom) and Iraq (Operation Iraqi Freedom) and who felt he needed additional assistance beyond employment counseling.

Upon arrival at the clinic for returning veterans, David expressed an interest in curbing his temper, and he attributed his marital and work-related problems to outbursts at home and on the job. He admitted to feeling depressed and unable to organize himself at work or at home. An engineer by training, David enlisted in the Army following completion of his degree in electrical engineering. An honors graduate of a prestigious university, David trained in the safe detonation of explosive devices and was assigned to an explosive ordinance division. He served three separate tours, one in Iraq and two in Afghanistan. In total, he was deployed to a warzone for nearly 3 years. He was discharged honorably from the Army in 2010 and returned to a small city in New England to begin his postmilitary life.

Upon presentation in the clinic, David spoke with pressured speech while describing his background and family history. His upbringing was largely unremarkable in that he was raised in a middle-class family by both parents whom he described as caring and conscientious people who afforded their three children a stable home in a good community with many educational opportunities. His decision to join the military was a function of deep-rooted patriotism in his family and a history of military service among the men. He was inspired to help the United States end terrorism following the attacks of 9/11.

David married his college girlfriend upon completion of his military training. She was supportive of his service, but reported considerable anxiety at the point of each of his deployments. Upon his return from a second deployment, she wanted him to return to civilian life. It was soon after this tour that his wife became pregnant and delivered a healthy daughter. At the time he sought help, his daughter was 3 years old.

Author Information and CME Disclosure

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Dr. Keane reports no competing interests

CONSIDERATION POINT A

At this point in the evaluation, the diagnoses that seem most appropriate for this patient would be:

A.1—— Major depressive disorder
A.2—— Posttraumatic stress disorder
A.3—— Alcohol abuse
A.4—— Bipolar disorder
A.5—— ADHD

CONSIDERATION POINT B

The methods employed to evaluate this patient included the following approaches:

B.1—— Structured diagnostic interviews
B.2—— Psychological tests and questionnaires
B.3—— Military history measures
B.4—— Mental status examination
B.5—— Amytal interview

CASE VIGNETTE PART 2: COMPREHENSIVE PSYCHIATRIC ASSESSMENT AND GATHERING FURTHER HISTORY

A comprehensive psychiatric assessment included a history of his military experiences, assignments, tours of duty, and a mental status exam. Also included in this assessment were: 1) the Deployment Risk and Resilience Inventory (DRRI) (1); 2) the Structured Clinical Interview for DSM-IV (SCID) (2); 3) the Clinician-Administered PTSD Scale (3); and 4) psychological tests including the PTSD Checklist (PCL) (4), the Beck Depression Inventory (BDI) (5), the Beck Anxiety Inventory (BAI) (6), and the Spielberger Anger Inventory (STAXI) (7). This approach to assessment was supplemented by specific questions regarding suicidal ideation and exposure to blasts while in training and in the warzone with a particular focus upon assessing mild traumatic brain injury (mTBI). His wife was also interviewed by herself in order to obtain additional information about their relationship and his functioning.

Results of the evaluation suggested that David possessed a loving and supportive family; his parents and wife were deeply concerned about his postdeployment functioning and were prepared to provide any necessary resources in order to foster optimal adaptation. Examining his combat exposure and related stressor exposures, it was clear that David experienced considerable stress during each of his three tours of duty, the most difficult of which was his third tour during the period of quelling the Sunni insurgency in Iraq. He described this period as filled with a barrage of firefights coupled with many, many initiatives to detonate improvised explosive devices (IEDs). Reports of IED attacks on American troops added to the anxiety that he and others in his division experienced. His predominant mode of coping was to shut down emotionally. This conscious effort to stem his own anxiety led to a sense of emotional numbing that continued to the present.

VIGNETTE CONTINUES: FINDINGS OF THE EVALUATION

Examination of the results of the structured diagnostic interviews suggested the following: David met diagnostic criteria for PTSD, major depressive disorder (MDD), and alcohol abuse. He also endorsed several symptoms of bipolar disorder, but didn't meet full diagnostic criteria for this condition. Using the SCID for measuring disorders other than PTSD revealed the presence of risky alcohol use, a problem that wasn't acknowledged in the psychiatric history. It was only upon specific questioning of the patient about his use of alcohol that a pattern of risky use and abuse emerged. Scores on the BDI and the BAI were clearly elevated and confirmed the concurrent presence of a broad-based anxiety and mood disorder. The PTSD Checklist score of 62 easily exceeded the threshold for PTSD caseness. Suicidal ideation was fleeting, with little information regarding a specific plan. Exposure to many blasts, some at relatively close range (50 yards), led to further exploration of mTBI, but there wasn't evidence that he'd ever lost consciousness or had other symptoms of postconcussive syndrome.

When the findings of the evaluation were explained to David and his wife, they were surprised. David had experienced very high levels of combat exposure even compared with others who served in these war zones. The periods in which he served were characterized by considerable contact with enemy troops and the use of explosive devices by the enemy. This comparative information surprised David as he felt that he experienced the same as others, no more or less. The issue of risky alcohol use or abuse was also notable in terms of their receipt of this information. David dismissed his drinking as normative for his peer group of returning veterans, while his wife clearly saw the alcohol use as a major problem but one about which she hadn't yet communicated her feelings to him.

Despite all of the information about PTSD in the media, this couple was surprised by the extent and the severity of this problem for David. In his view, he was

minimizing these symptoms as common ones that everyone in a war zone experiences. From her perspective, she knew that he was distant, that he didn't sleep very well, and that he had nightmares. They actually spoke very little about his time in the war zones and she was surprised at his level of symptomatology. She saw only the ease with which he became angry and his sleeplessness. The more cognitive symptoms of reliving the war, preoccupation with the deaths of his buddies, and his sense of survivor guilt were not at all apparent to her. She noted that he was jittery and startled easily, but felt that these problems would diminish over time.

Treatment options offered to David were all outpatient-based. His highest priority was to improve his sleep and to address the nightmares he experienced several nights each week. He felt that if he could accomplish this, then he would be less angry, depressed, and more likely to be able to work. Options offered to David were the use of a selective serotonin reuptake inhibitor (SSRI), but it was explained that this might take weeks to months to exert its full effects (8). They agreed to its use. Secondly, we offered him a trial with prazosin, an antihypertensive medication that was observed to reduce the frequency and intensity of nightmares and thereby improve sleep in patients with PTSD (9, 10). Again, they agreed to a trial of prazosin.

CONSIDERATION POINT C

For psychological treatments for patients with PTSD, there are several treatment options with substantial evidence bases. In this particular case, which treatment might be optimal given the circumstances:

C.1—— Exposure therapy
C.2—— Cognitive processing therapy
C.3—— Behavioral couples therapy for alcohol
C.4—— Cognitive behavioral conjoint therapy for PTSD
C.5—— Both 3 and 4 concomitantly

VIGNETTE CONCLUDES

Next, we offered the available evidence-based cognitive behavioral treatments for PTSD: exposure therapy, cognitive processing therapy (CPT), and couples therapy for PTSD. Exposure therapy has many facets that include patient education about trauma, skills training, and processing of new perspectives on the experiences associated with traumatic events. Prolonged exposure therapy is one form of exposure therapy that is easily the most well studied approach to treating PTSD (11). Other forms include nightmare rehearsal training, imagery rehearsal, narrative exposure therapy, and written disclosure therapy (12–14). All possess a significant evidence base.

CPT is also extensively studied in a variety of PTSD patient types and possesses a strong evidence base (15, 16). This therapy involves promoting cognitive reappraisals of the traumatic experiences, teaching alternative views, providing a variety of specific behavioral coping strategies, and challenging key cognitive distortions about the individual, the traumatic situation, and the future.

The third option was for couples conjoint therapy for PTSD (16). This approach involves emotional processing in the context of couples treatment. It promotes the use of the couple as a supporting entity that can mitigate the impact of trauma. There is also considerable education contained within the treatment package. Importantly, the couple is the unit of treatment and this approach implies that it is through a couple's communication and support that the emotional responses associated with trauma exposure can be managed effectively (17). Importantly, there is considerable evidence to support the use of behavioral couples therapy to reduce drinking and promote sobriety (18). Integrating these two approaches to the treatment of PTSD and alcohol abuse was viewed by David and his wife as the clear treatment of choice. The presence of a supportive and loving relationship made this option for psychotherapy a compelling choice for this couple.

ANSWERS, SCORING, RELATIVE WEIGHTS, AND COMMENTS

CONSIDERATION POINT A

A.1—— **(+3)** *Major depressive disorder*. Presentation of dysphoria, mood dysregulation, and sleep problems are all components of a major depression. This should be a consideration.

A.2—— **(+3)** *Posttraumatic stress disorder*. The presence of a significant set of exposures to traumatic events constitutes major risk factors for the possible development of PTSD. A high-risk position in a combat zone during times of heavy conflict plus multiple tours of duty also add to the possibility that PTSD might be present. Sleep dysregulation, temper problems, marital difficulties, and

vocational problems all constitute important symptoms and/or associated features of combat-related PTSD.

A.3—— **(+3)** *Alcohol abuse*. Alcohol Abuse is common among those who serve in the military and it is even more common among those who develop PTSD. Alcohol abuse often follows the emergence of PTSD symptoms in time as those suffering attempt to self-medicate symptoms such as mood problems, anxiety, and sleep disturbances.

A.4—— **(+1)** *Bipolar disorder*. The presence of pressured speech can accompany bipolar disorder as well as PTSD. When facing a patient with pressured speech, the most common rule out diagnosis is bipolar disorder, but this is also present with a small cohort of patients with combat-related PTSD. Both disorders can occur concurrently, but it is important to evaluate the extent to which there is a history of cycling of mood states, cycling of irritability, and cycling of mania/hypomania. In this instance, the pressured speech was a function of PTSD and the patient's efforts to not avoid the most difficult aspects of his traumatic life events.

A.5—— **(0)** *ADHD*. Aside from speaking quickly and temper outbursts that might raise a question of high psychomotor activity levels, there were no data presented to suggest that ADHD was a part of this patient's history or presentation, and his occupational achievements (honors in electric engineering, successes with safe detonation of explosive devices while deployed) might be difficult for a person with attentional deficits. Nonetheless, ADHD is sufficiently common that it is worth briefly entertaining the possibility.

CONSIDERATION POINT B

B.1—— **(+3)** *Structured diagnostic interviews*. The structured diagnostic interviews yielded important information on the actual extent to which this patient met diagnostic criteria for PTSD (the CAPS), alcohol abuse, major depressive disorder (SCID), and didn't meet criteria for bipolar disorder (SCID). The combination of these two interviews gave important information to set the stage for the interventions to be considered by the therapist and the patient. Information on suicidal ideation is also elicited by the SCID.

B.2—— **(+3)** *Psychological tests and questionnaires*. The psychological tests added additional information on the severity of the PTSD symptoms (PCL), depression (BDI), and anxiety/stress (BAI). The information on the pervasiveness of anger and irritability came from the Spielberger Anger Inventory, the most commonly used self-report measure of this emotion. These questionnaires can be administered periodically during the course of care to assess the effectiveness of interventions in mitigating target symptoms.

B.3—— **(+3)** *Military history measures*. The Deployment Risk & Resiliency Inventory is a self-report measure that possesses norms and comparative information for people who've served in the current wars. This measure provides a comprehensive military history of exposures to the many adverse experiences that one can have in war theaters. This standardized method of taking a military history saves time for the clinician and guides further questions in the unstructured clinical interview.

B.4—— **(+3)** *Mental status examination*. Mental status exams can follow either a standardized or nonstandardized approach. For patients at risk for suicide or homicide it needs to be a common component of the examination. Assessing for the presence or absence of psychotic symptoms, suicidal/homicidal ideation, and cognitive decline can provide important information to the clinician as s/he intervenes.

B.5—— **(−3)** *Amytal interview*. The use of pharmacologic agents such as barbiturate "truth serum" infusions is not an evidence-based

procedure for the evaluation of PTSD, MDD, or mTBI.

The use of inventories, mental status examination, structured interview, and psychological testing approaches to a diagnostic evaluation of this patient assisted in a comprehensive evaluation of the most suitable diagnostic categories conferred, the degree of symptomatology present in comparison to others, the conduct of a complete military history and related exposures, plus the ruling out of a possible psychotic condition (bipolar disorder).

CONSIDERATION POINT C

C.1—— **(+2)** *Exposure therapy*. Exposure therapy in its many forms possesses an extensive body of evidence for the successful treatment of PTSD. This treatment should be considered as a frontline treatment. Yet, the presence of an alcohol abuse diagnosis and the availability of a supportive spouse suggest that other evidence-based approaches be considered by the clinician.

C.2—— **(+2)** *Cognitive processing therapy*. CPT is also a frontline treatment for PTSD with studies supporting its use in PTSD derived from various traumatic life events including combat. Yet, the presence of a supportive spouse and the alcohol diagnosis suggest that other approaches be considered.

C.3—— **(+2)** *Behavioral couples therapy for alcohol*. This approach possesses one of the strongest evidence bases for patients seeking treatment for risky and abusive alcohol use. This is a frontline treatment for those patients with a spouse or partner who remains committed to the relationship and to overcoming the problems associated with drinking. Yet, the data are less clear on the use of this treatment in the presence of combat-related PTSD.

C.4—— **(+2)** *Cognitive behavioral conjoint therapy for PTSD*. This treatment option is a new addition to the therapist's armamentarium. The evidence base is strong and growing and its effectiveness occurs within the context of the intimate interpersonal relationship. This promotes generalization of the skills learned in the context of therapy to the home environment.

C.5—— **(+3)** *Both 3 and 4 concomitantly*. Combining the virtues of cognitive behavioral conjoint therapy for PTSD with behavioral couples therapy in this specific case seems ideal. The supportive and committed spouse attended all sessions whether she was in the therapy room or not. Both the patient and his wife perceived this approach as critical to overcoming the problems of PTSD, alcohol abuse, and marital distress.

YOUR TOTAL

Decision Point	Score	Ideal Score
A		10
B		12
C		11
Total		33

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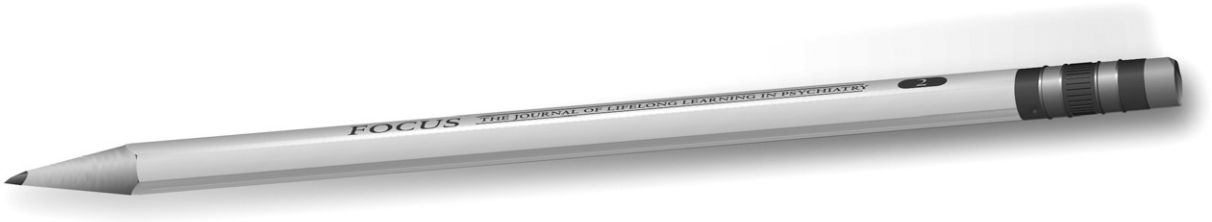

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