TRAUMA CASE-STUDY MILITARY

School of Behavioral Science, Liberty University

TRMA-830

Brief Summary

John is a 27-year-old single male who served eight years in the Army beginning at 18 years of age. His service with the military included three tours of duty in Iraq and Afghanistan, lasting 6 to 9 months each. John presents with nightmares, flashbacks, and anxiety, difficulty concentrating, decreased energy, depressive mood, and withdrawal from both physical and social activities. He is in reasonably good health. John has also become withdrawn from his family and girlfriend. Also, John has resorted to drinking as a means of coping with stress and anxiety which has resulted in self-destructive behavior. In addition, John's score on the Beck Depression Inventory-2 indicated mild-to-moderate depression while his score on the Beck Anxiety Inventory indicates that he is also suffering from mild to moderate anxiety. His score on the Beck Hopelessness Scale indicated minimal hopelessness while his score on the Beck Scale for Suicide Ideation indicated no suicidal ideation. John's results from his Mini Mental Health Status Exam indicates normal cognitive functioning. John's score on the Combat Exposure Scale indicates heavy exposure to wartime stressors.

First Assessment Instrument Interpretation
Combat Exposure Scale

The Combat Exposure Scale (CES) is a 7-item self-report that is used to assess wartime stressors of combatants and is primarily used in studies of Vietnam veterans (Wilson & Keane, 2006). The scale is rated based on a 5-point frequency, 5-point duration, or 45-point degree of loss (Combat Exposure Scale (CES), 2018). The scales requests replies to various types of combat exposure including combat patrols, situations regarding enemy fire, frequency of rounds fired at enemies, frequency of witnessing others being hit by incoming or outgoing rounds, and the frequency of dangerous situations that may have resulted in either death or injury. John's total score on the CES was 40 which indicates heavy exposure to combat stressors. Below are the scores, along with evidence, from John's CES:

1) Did you ever go on combat patrols or have other dangerous duty? **5 (51+ times)**
    - "…easily more than 100 of them (patrols)."
2) Were you ever under enemy fire? **5 (7+ months)**
    - "…during the total of 36 months that he was deployed "in-country," he was under fire for over half of that."
3) Were you ever surrounded by the enemy? **3 (3-12 times)**
    - "On at least four of the ambushes, he knows he and his platoon were surrounded by the enemy…"
4) What percentage of the soldiers in your unit were killed (KIA), wounded or missing in action (MIA)? **3 (26-50%)**
    - "…had a pretty high KIA (killed in action) and WIA (wounded in action) rate of about 30%."
5) How often did you fire rounds at the enemy? **5 (51+ times)**
    - "…was in at least 61 or 62 "firefights" with enemy combatants."
6) How often did you see someone hit by incoming or outgoing rounds? **4 (13-50 times)**
    - "…at least 40 to 50 times (someone was hit by incoming fire."
7) How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)? **4 (13-50 times)**
    - **"…**there were about 18 or 19 situations… where he and his team were ambushed and pinned down…"

Second Assessment Instrument Interpretation
Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) is a 5-item screen that is used to determine the likelihood of PTSD in individuals in primary care settings (Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), 2018). Exposure to lifetime exposure of traumatic events is assessed (Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), 2018).

The determining factor is whether a respondent either denies or admits to any lifetime exposure of a traumatic event (Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), 2018). Denial of exposure is scored with 0. Yet, if any lifetime exposure is indicated then the respondent is presented with 5 additional questions regarding the overall effects of the exposure within the past month (Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), 2018). John's score on the PC-PTSD-5 was 5, therefore PTSD is deemed probable. Further assessment to determine a diagnosis of PTSD is required and can be achieved with a structured interview instrument such as the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). Below are the answers, provided by John, along with evidence, to determine his provisional diagnosis of PTSD:

In the past month, you have…

1) had nightmares about the event(s) or thought about the event(s) when you did not want to? **YES**

- "…he keeps having nightmares about his experience."

2) tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? **YES**

"…he does his "best to push the images out of his mind (vivid pictures/flashbacks), but they keep coming back."

3) been constantly on guard, watchful, or easily startled? **YES**

- "I'm "constantly on guard" when I'm "driving or walking down the street."
- "It's like any little sound or noise or a car coming from nowhere makes me jump…"

4) felt numb or detached from people, activities, or your surroundings? **YES**

- "…emotionally is just not all there, maybe 'numb' is a good word; I don't know how to explain it…"

5) felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused? **YES**

- "…I know it is all my fault…"
- "…I'm guilty! I'm angry at myself for letting everyone down! All of this didn't have to happen if I'd just done my job!"

Third Assessment Instrument Interpretation
Clinician Administered PTSD Scale for DSM-5

The Clinician-administered PTSD scale for DSM-5 (CAPS-5) is widely used and extensively validated structured interview containing 30 items that can be used to render a diagnosis of PTSD (Weathers et al., 2018). It is considered the gold standard of PTSD assessments and is administered by clinicians and clinical researchers who are knowledgeable of PTSD. The presence and severity of specific symptoms indicate the likelihood that John will develop PTSD. The expression of her symptoms occurred more than 6 months after the traumatic event yet have been occurring for more than thirty days which meets the month-long threshold required for a diagnosis of PTSD. Reassessment should be administered at least thirty days after the onset of symptoms to either include or exclude a diagnosis of PTSD. The results of John's CAPS-5 assessment are listed in Table 1.

Table 1

John's CAPS-5 Assessment and Evidence

CLUSTER A		
Criterion	Score	Evidence
Exposure to a traumatic event	1 - Met	"John is a 27-year-old single man who served eight years in the Army (joining when he turned 18), and served three tours (each about 6-9 months) of duty in Iraq and Afghanistan."
CLUSTER B		
Intrusive Memories	Extreme (4)/ Yes (1)	"….has vivid mental pictures during the day when he is just sitting and watching television."

Distressing dreams	Extreme (4)/ Yes (1)	"...he describes the IED, the explosion, feeling the pain of his legs being shredded, feeling the Humvee flipping, and the excruciating pain in his back."
Dissociative reactions	Extreme (4)/ Yes (1)	"...it is almost like being right back in that war zone, and being back on patrol."
Cued psychological distress	Extreme (4)/ Yes (1)	"The more he finds himself thinking about what happened the more he "feels on edge, watching out for anything that can happen..."
Cued physiological distress	Extreme (4)/ Yes (1)	"...he says his "heart starts beating faster, my chest starts hurting, my hands start shaking; I think I'm dying, even though I know I'm safe back 'state-side."
Cluster B Score 20/5		
CLUSTER C		
C1 - AVOIDANCE OF MEMORIES	Extreme (4)/ Yes (1)	"...he does his best to push the images out of his mind, but they keep coming back."
C2 - AVOIDANCE OF REMINDERS	Extreme (4)/ Yes (1)	"..."throws himself into any kind of physical work he can find: yard work, construction work, lifting weights, anything."
Cluster C Score 8/2		
CLUSTER D		
D1 - INABILITY TO RECALL EVENT	Mild (1)/ No (0)	"Strange, I can't even remember the street name we were on even though I had travelled it about 100 times on patrol. "
D2 - EXGGERATED NEGATIVE BELIEFS	Extreme (4)/ Yes (1)	"A man died because I was so stupid..."
D3 - DISTORTED COGNITIONS OF BLAME	Extreme (4)/ Yes (1)	"...I know it is all my fault. I was 'topside' at the gun, and I should have seen the IED before we got close to it."
D4 - PERSISTENT NEGATIVE BELIEFS	Extreme (4)/ Yes (1)	"...I'm angry at myself for letting everyone down! All of this didn't have to happen if I'd just done my job!"
D5 - DIMINISHED INTEREST IN ACTIVITIES	Extreme (4)/ Yes (1)	"...He used to like to hike...and ride his mountain bike...pretty much doesn't want to do any of those things these days."
D6 - DETACHMENT FROM OTHERS	Extreme (4)/ Yes (1)	"... just want people to leave me alone and stop asking me if 'I'm alright."
D7 - PERSISTENT INABILITY TO EXPERIENCE POSITIVE EMOTIONS	Extreme (4)/ Yes (1)	"...he says he "emotionally is just not all there, maybe 'numb' is a good word..."
Cluster D Score 21/5		
CLUSTER E		
E1 - IRRITABLE BEHAVIOR	Extreme (4)/ Yes (1)	"...blowing up' and yelling at his family and friends for no good reason is happening every week."
E2 - RECKLESS BEHAVIOR	Extreme (4)/ Yes (1)	"...he "knows it's dangerous to be driving when he's had a few too many," and while I've run off the road a few times, I still always make it home in one piece." "...I have had a few close calls with almost getting creamed by a 'semi' on the interstate..."

E3 - HYPERVIGILANCE	Extreme (4)/ Yes (1)	"...I'm constantly on guard when I'm driving or walking down the street."
E4 - EXAGGERATED STARTLE RESPONSE	Extreme (4)/ Yes (1)	"...any little sound or noise or a car coming from nowhere makes me jump"
E5 - PROBLEMS WITH CONCENTRATION	Extreme (4)/ Yes (1)	"...Can't concentrate or think straight"
E6 - SLEEP DISTURBANCE	Extreme (4)/ Yes (1)	"..."always a great sleeper, getting around seven hours each night and greeting the dawn each day; now I'm lucky to get 3-4 hours."
Cluster E Score 24/6		
CLUSTER F		
F - DURATION OF DISTURBANCE > 1 Month	9 months/Yes	"She then begins to relate that about two weeks ago she started to have repeated dreams..."
CLUSTER G		
G - SUBJECTIVE DISTRESS	Extreme (4)/ Yes (1)	"...If I'm alright, would I be coming to you? "
G - IMPAIRMENT IN SOCIAL FUNCTIONING	Extreme (4)/ Yes (1)	"...I don't want to do anything and I don't want to be around anyone else."
G - IMPAIRMENT IN OCCUPATIONAL FUNCTIONING	Extreme (4)/ Yes (1)	"...I wasn't sleeping, I started making big mistakes on the job, and the boss took me off full-time."
Cluster G Score 12/3		

Primary and Secondary Diagnostic Impressions

John's score on the Beck Depression Inventory indicates that he he has mild-to-moderate depression. His score on the Beck Anxiety Inventory indicated a mild-to-moderate case of anxiety. The mini-mental status exam was also administered, and results indicated that John's cognitive functioning is normal. Considering the results from the Combat Exposure Scale, the PC-PTSD-5, and the Clinician-Administered PTSD Scale for DSM-5 interpretation, a primary and secondary diagnosis has been deduced as follows.

Primary Diagnosis with Culture/Gender Issues, Suicidal Risks

Based on the duration and severity of John's symptoms he has exceeded the required criteria for a diagnosis of **Internal Classification of Disease (ICD) Code 309.81.F43.10 Posttraumatic Stress Disorder with Delayed Expression.** Posttraumatic Stress Disorder (PTSD) with delayed expression is a trauma or stressor-related disorder in which symptoms

are persistent for more than one month after the occurrence of a qualifying traumatic event (American Psychiatric Association, 2013) and do not appear until at least six months after exposure to a traumatic event. John was discharged from the army nine months ago. However, his nightmares began only two months agon while his flashbacks began to occur one month ago per the statements provided in his interview. PTSD is more prevalent amongst veterans and others whose occupation exposes them to traumatic risks such as first responders (American Psychiatric Association, 2013). Symptoms include exposure to a traumatic event such as war and combat, actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013). The highest rates of PTSD occurs in survivors of sexual violence, military combat, and captivity (American Psychiatric Association, 2013). There is a higher prevalence of PTSD in women than men. Women tend to experience PTSD longer than men (American Psychiatric Association, 2013). This can be attributed to the likelihood of women being exposed to crimes related to interpersonal violence such as rape and domestic violence.

A diagnosis of PTSD requires the presence of at least one qualifying traumatic event along with symptoms that fall within all four symptom clusters (re-experiencing, avoidance, negative cognition and mood, and arousal) (American Psychiatric Association, 2013). In addition, the symptoms must cause clinically significant impairment in social, occupational, and other domains of functioning (American Psychiatric Association, 2013). Also, the symptoms must not be related to the effects of a substance, medical condition and also not better explained by brief psychotic disorder (American Psychiatric Association, 2013). John states that he has no desire to commit suicide and his score on the Beck Scale for Suicide Ideation was 0. Therefore, he does not present as a risk for suicide. However, the possibility of suicidal ideation should be closely monitored. Veterans who have served in Iraq and Afghanistan and who have been either diagnosed with or present with symptoms associated

with PTSD experience an increase in both suicide ideation and suicide completion (Ramchand et al., 2015). The DSM-5 criteria for a diagnosis of PTSD with delayed expression is evidenced by information gleaned from his CAPS-5 assessment found in Table 1.

Secondary Diagnosis with Culture/Gender Issues, Suicidal Risks

John's reliance on alcohol consumption to alleviate his anxiety and aid in the avoidance of facing his traumatic memories has resulted in risky behavior as well as social and recreational impairment. This author recommends a secondary diagnosis of **Internal Classification of Disease (ICD) Code 303.90.F10.20, Alcohol Use Disorder, Severe** (American Psychiatric Association, 2013) due to the presence of 6 or more symptoms. Alcohol use disorder (AUD) commonly co-occurs with PTSD amongst individuals harboring unhealed trauma (Possemato et al., 2017). Of the 39% of veterans seeking primary care at the Veterans Administration that are diagnosed with PTSD, 27% screened positive for hazardous drinking (Possemato et al., 2017). In addition, alcohol use disorder may be attributed to genetic predisposition, which accounts for 40%-60% of the risk variance (American Psychiatric Association, 2013). However, there is no evidence of genetic predisposition based on the information contained in John's interview. Culturally, alcohol consumption is considered the most frequently utilized form of intoxication (American Psychiatric Association, 2013). Males utilize alcohol at a higher rate than females but may be less affected physically due to their usually larger size as compared to women (American Psychiatric Association, 2013). As previously mentioned, John is adamant about not considering suicide and this thought is corroborated by his score of 0 on the Beck Scale of Suicide Ideation. However, severe intoxication is an important contributor to suicide risk (American Psychiatric Association, 2013).

Culturally, individuals of European descent are likely to experience generalized

anxiety more often than those of non-European descent (Asian, Native American, African, Latin) (American Psychiatric Association, 2013). In addition, females are two times more likely to experience generalized anxiety when compared to experiences reported by men. Both males and females experience similar symptoms as well as comorbidity of other mental health disorders. However, comorbidity in males is most likely to be related to substance use disorders. This would help to explain John's reliance on alcohol consumption to help relieve his symptoms of anxiety. Below are the diagnostic criteria for alcohol use disorder along with evidence of criteria being met based on John's interview:

List of Symptoms That Meet Criteria for Diagnosis of Alcohol Use Disorder, Severe

1) **Substance is often taken in larger amounts and/or over a longer period than the patient intended.** "…drinking a little more since I've been back than I did while serving…"
2) **A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from effects.** "…staying out later and later at bars"
3) **Craving or strong desire or urge to use the substance.** "…honestly, I really wish I had a drink with me now as we're talking about all this stuff."
4) **Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.** "…I have missed a few family functions that made my parents made at me…" "…my girlfriend has asked me to go places …but when I get to the bar time goes by and I forget. This has caused a lot of fighting between us…"
5) **Continued substance use despite having persistent or recurrent social or interpersonal problem caused or exacerbated by the effects of the substance.** "… I have missed a few family functions that made my parents made at me…" "…my girlfriend has asked me to go places …but when I get to the bar time goes by and I forget. This has caused a lot of fighting between us…"

6) **Important social, occupational, or recreational activities given up or reduced because of substance use. "…**I don't feel like doing anything other than my usual: get up, do some work, go to bars and hangout, come home, go to bed, not dream, repeat."
7) **Recurrent substance use in situations in which it is physically hazardous.** "… I've run off the road a few times…" "…I have had a few close calls with almost getting creamed by a 'semi' on the interstate, and I think I may have knocked someone's mailbox over one time about a month ago…"

Recommendations

Recommendation 1

Based on John's dual diagnosis of PTSD and AUD this author recommend an approach that simultaneously addresses John's trauma as well as his misuse of alcohol. The first recommendation is Concurrent Treatment of PTSD and Substance Use Disorders using Prolonged Exposure (COPE). COPE is a manualized, integrated cognitive behavioral therapy for comorbid PTSD and AUD that is dispensed over 12 weekly 90-minute sessions (Korte et al., 2017). The first three sessions focus on goal-setting, psychoeducation related to AUD and PTSD, coping skills to hep manage cravings, and introduction to prolonged exposure (PE) (Korte et al., 2017). In vivo exposure begins in session 3 and continues throughout the duration of the program (Korte et al., 2017). Imaginal exposure begins in session 4 with each session lasting between 30-45 minutes (Korte et al., 2017). Sessions are recorded so that patients can replay the session once per week while replaying the imaginal exposure recordings daily (Korte et al., 2017).

Recommendation 2

The second recommendation is Prolonged Exposure (PE) therapy. PE is a form of cognitive behavioral therapy (CBT) that is delivered in eight to 15 sessions and is aimed at

teaching clients to confront their fears related to specific traumatic events (Prolonged exposure (PE), 2020). John's nightmares are constant reminders of the terrifying circumstances he confronted throughout his multiple tours of duty. The daily flashbacks are debilitating and requires addressing so that John can gain increased functionality in several domains of his life including personal, occupational, and professional. Treatment begins with the therapist gaining a clear understanding of the client's past experiences while offering psychoeducation to the patient regarding the treatment protocol (Prolonged exposure (PE), 2020). Imaginal exposure involves the patient describing the event in the present tense (Prolonged exposure (PE), 2020). The patient and therapist process emotions that arise. The sessions are recorded and the patient is asked to review the session while continuing to process emotions while utilizing breathing and relaxation techniques. In vivo exposure is also utilized (Prolonged exposure (PE), 2020). This type of exposure is used to help patients confront feared stimuli that exists outside of therapy such as social settings, specific location, or situations. The client and patient decide on a list of feared stimuli to be confronted and the patient is asked to gradually confront the stimuli at a pace that is comfortable for the patient (Prolonged exposure (PE), 2020). One of the goals of this process is to offer the client an opportunity to experience success in managing emotions (Prolonged exposure (PE), 2020).

Recommendation 3

The final recommendation is psychopharmacological treatment. "Medications that target SUD and PTSD concurrently are not only beneficial in preventing PTSD symptom exacerbation but can facilitate engagement in psychosocial treatments, particularly exposure therapies" (Back et al., 2017, p. 2). Heavy alcohol usage has been shown to be greatly reduced in patients receiving desipramine (SNRI) along with naltrexone (SSRI) (Back et al., 2017). Naltrexone has proven successful in the reduction of alcohol cravings as well as a

supplement to psychosocial interventions such as cognitive-based therapy and motivational interviewing (Back et al., 2017). Prazosin has been proven highly effective in reducing PTSD-related nightmares and daytime hyperarousal symptoms while also improving sleep for PTSD patients (Back et al., 2017). In addition, prazosin has also proven effective in the reduction of alcohol consumptions and cravings (Back et al., 2017).

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