

Management of Post Traumatic Stress Disorder Using Combat Stress Treatment Principles-A Case Report

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Abstract

Combat stress casualties are only generated by war. However, military psychiatrists need to acquire the experience and skills that they would need before they are ever faced with their first combat stress casualty. Non-combat post traumatic stress disorder patients present the best approximation to combat stress casualties. This case study demonstrates how combat stress treatment principles can be successfully applied to a case of non-combat post traumatic stress disorder patient. It is not the intention of this paper to demonstrate whether the combat stress management protocol is superior to other methods or protocols. Recommendations are made on methods to identify post traumatic stress disorder patients and how to seize every available opportunity to practise combat stress treatment principles.

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Introduction

The development of the diagnostic category of post traumatic stress disorder (PTSD) is closely intertwined with military history. The development of sophisticated stress-response conceptualizations can be traced through the theories of combat stress reactions.¹ Wars provide large numbers of PTSD sufferers, as peacetime extreme traumatic stressors occur sparingly and affect people in numbers which would be considered small when compared even to just a single battle. Even so, Breslau et al² found that 4 in 10 Americans have been exposed to a major traumatic event before the age of 30, out of which 1 in 4 developed PTSD. Other recent epidemiological studies have indicated a lifetime prevalence of developing PTSD in the community of between 8% and 15%.^{3,4}

Many treatment modalities and protocols exist to treat PTSD with varying degrees of success. Military psychiatry has adopted certain principles in the management of combat stress disorders (CSDs), itself a form of PTSD. This paper demonstrates the application of these principles on a patient suffering from non-combat PTSD and attempts to draw implications of such applications in the practice of military psychiatry in Singapore.

Case Report

A 22-year-old single, Chinese, full-time National Service Naval Medical Orderly was referred by his unit medical officer 10 days after he was psychologically traumatised as a result of attending to a person who had committed suicide.

History and Presenting Symptoms

The patient was on duty at his medical centre when he was activated at 7.08 am to attend to a casualty who was found hanged on board a ship. He was directed to the "chiller-clad", a part of the ship, where he was confronted by the gruesome sight of the deceased whose face was blue and bloated with eyes half-opened, and a protruding engorged tongue. He was stupefied, and his "mind went blank". He only felt for the pulse and on finding it absent, he merely evacuated the body to the medical centre. Upon arrival at the medical centre, his colleagues reproached him for not performing cardiopulmonary resuscitation (CPR). They took over the management and CPR was initiated and continued until the body arrived at the hospital. The casualty was pronounced dead upon arrival.

Later the same day, his medical officer questioned him on his actions. He admitted to his minimal management and expressed guilt feelings over it. Despite being given the rest of the day off, he returned to his medical officer the next day, tearful and distressed. He was unable to fall asleep for the whole night. There were also recurrent and intrusive distressing recollections and images of the deceased.

He was given more days-off and more counselling sessions by his medical officer, including an urgent one at 2.30 am. He returned to work 6 days after the incident but was still very distressed by it. He was referred to this author but he defaulted the appointment because of the perceived stigma attached to seeing

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a psychiatrist. He finally turned up for his appointment 10 days after the incident when his symptoms became intolerable.

At his first consultation, he was still having recurrent and intrusive recollections of the face of the deceased, usually triggered off by themes of death and dying, e.g. from television shows. He was still having poor sleep initiation and maintenance. He had dreams and nightmares frequently and he felt unrefreshed on awakening. He has since become rather restless and pervasively hypervigilant. His anxiety level increases whenever he returned to the medical centre and whenever he spoke about his experience to his medical officer and to this author. He has not been able to talk to anyone else about it. He was strongly phobic about going on board any ship. His appetite has become poor. He also developed a restricted range of effect, feeling detached and estranged from others. He had markedly diminished interest or participation in significant activities, and a sense of a foreshortened future. The incident has also reactivated guilt feelings over his mother's death.

Relevant Background History

The patient, the youngest of 7 children, was scapegoated shortly after he was born, because his father was diagnosed to have lung cancer. He was banished from home for 2 years, during which time his father died. Thereafter he was much pampered by his mother. One year prior to his presentation, his mother died suddenly of acute myocardial infarction at home while he was out with his friends. It took him a few months before he stopped blaming himself for not being present to save his mother.

A few months prior to his presentation, he apparently altruistically gave up his girlfriend to his close friend without their knowledge. However, up until the time of presentation, he had yet to come to terms with the loss.

His birth, developmental milestones and educational history were otherwise unremarkable. His sister described him as an ostensibly strong person who is emotionally very weak. Where he used to be sociable and outgoing, he has become quieter and stayed at home more since his mother's death.

Mental State Examination

Significant findings from the Mental State Examination at his first consultation include a noticeable paucity of gestures as he sat hunched in his chair. He was expressionless and appeared detached even as he spoke about the incident, but subsequently he admitted to feeling anxious during the recounting. His mood was mildly depressed. There were no symptoms of psychosis. No abnormality was detected on physical examination.

Management

The patient was managed using treatment principles of Combat Stress Reaction, viz Proximity, Immediacy, Expectancy and Simplicity. On the principle of Immediacy, he was given an urgent appointment on the very day his medical officer made the phone referral, although he defaulted that appointment. On the principle of Expectancy, the patient was first reassured that he was a normal person reacting to an abnormal experience. He was then informed of this author's aim to help him return to the medical centre and subsequently board a ship in the very near future. He was reminded of both points at every subsequent appointment. Returning him to the medical centre and a ship is in accordance with the principle of Proximity. The principle of Simplicity involved using simple non-pharmacological measures to treat him, including rest, recounting of the event, reassurance, rehabilitation and resolution of other needs. His other needs include coming to terms with his mother's death and the recent loss of his girlfriend, and these were resolved after a course of Brief Dynamic Psychotherapy. In between appointments, his homework involved having to recount his experiences to other people.

Progress

On his first review, just one week after the first consultation, he had already made significant improvements. His appetite was much improved. His sleep initiation was shortened to an hour. He stopped having dreams but his sleep was still interrupted. The intrusive recollections became only occasional. However he was unable to carry out his homework of recounting his experiences to others. After that first review, he was able to return to work at the medical centre but on light duties and excused night duties for a month. He was reviewed weekly over the next 3 weeks during which he was able to recount his experiences on a number of occasions to some people. Whenever he did so, he experienced a transient aggravation in his sleep disturbance and level of anxiety but the severity of these aggravations progressively decreased with each subsequent recounting.

One month after his first consultation, his appetite had normalised and his sleep was almost normal. However, he was still feeling emotionally numb. Shortly after this review, he was on sailing duties for a month. Upon his return, he reported at follow-up that he coped well in his duties as a medical orderly, although he was still not fully confident. He also happened to board a ship similar to the one on which he attended to the suicide victim. There was neither psychological nor physiological signs of distress on this exposure. He had no reason to enter the "chiller-clad" section of the ship but there was no emotional distress when he imagined

himself doing so. He had by then also come to terms with his mother's death and stopped pining for his ex-girlfriend.

His last appointment with this author was 6 months after the first consultation. He had by then been on numerous sailing trips without any adverse reaction at all. He had also recovered his self-confidence. His sleep had normalised. He no longer felt numb nor harboured any sense of a foreshortened future. He even made plans to go overseas for his tertiary education. Therapy was terminated and he completed his fulltime National Service one month after that.

Discussion

PTSD has been known under various names throughout military history, including "nostalgia", "irritable heart of soldiers", "war neurosis", "shell-shock" and "combat exhaustion". In 1952, the combat stress reaction was subsumed under the Diagnostic and Statistical Manual of Mental Disorders (DSM) I category of "gross stress reactions". In 1968, DSM II renamed this category "transient situational disturbances". In 1980, in the wake of the Vietnam War, DSM III introduced the current term of PTSD. This name has been retained through DSM III-R and to the present DSM IV, with slight modifications to the diagnostic criteria. This patient fulfilled the DSM IV⁵ criteria for PTSD. His symptoms, which fulfil the Criteria B, C and D of DSM IV, had persisted for at least 6 weeks from the time he first experienced them although efficacious treatment has reduced the severity of these symptoms. It is also noteworthy that Garb et al⁶ has gone further to sub-classify Combat Stress Reaction into several varieties, for which similar parallels can be drawn for PTSD.

It is in the interest of every military force to reduce casualties and salvage injured fighting men. To reduce psychiatric casualties is no exception. The vast experience gained in military psychiatric practice has found applications relevant to the civilian population. Past methods of treating combat stress ranged from abreaction, electric shocks and sodium amytal¹ to ignoring the condition or worse, imprisonment or summary execution.⁷ Current measures in managing a patient with PTSD include psychotherapy, exposure therapy, pharmacotherapy, electroconvulsive therapy, and more novel methods such as Eye-Movement Desensitisation^{8,9} and Image Habituation Training.¹⁰

The Combat Stress Disorder treatment principles of Proximity, Immediacy, Expectancy and Simplicity, first discovered during the First World War, were subsequently tested and validated in the Second World War and they remain valid today for managing Combat Stress casualties.¹¹⁻¹³ Treatment principles in acute PTSD can be summarized by the mnemonic BICEPS-Brief, Immediate, Centrally administered, with Expectation

of return to normal function, Proximately given, and Superficial.¹⁴ The influence of Combat Stress treatment principles is clear.

In Combat Stress Disorders, the crux of the treatment principle of Immediacy is to intervene as soon as possible, so as to avoid letting the ailment set in and become a chronic problem which is even more difficult to treat. Furthermore, when a stress casualty inappropriately remains in the midst of the physically wounded casualties, his symptoms tend to escalate to the point where he is or appears to be, as badly off as they are.¹⁵ Davidson and Smith¹⁶ support the need for early intervention and rapid access to treatment for PTSD patients. They added that PTSD is still a diagnosis which is frequently missed by doctors, including psychiatrists. While it is commendable that the unit medical officer recognised that the patient has undergone a traumatic experience and tried to help the patient by counselling, he did not realise that it might have been a case of PTSD in evolution. When the patient appeared not to be responding to the counselling, his medical officer then referred the patient to this author. This author adhered to the principle of Immediacy, although unfortunately the patient delayed the appointment by a further 4 days for fear of stigmatization.

The unit medical officer had not applied the principle of Proximity when he allowed the patient to go home to recover from his traumatic experience. In the days where the principle of Proximity was yet to be discovered, all psychiatric casualties were evacuated to long term facilities far away from the war zone. The resultant recovery rate from Combat Stress was less than 5%, as compared to 70% to 80% of similar casualties returning to full combat duties when the Combat Stress Treatment Principles were applied.¹⁵ The principle of Proximity works via the concept of exposure as in behaviour modification for treatment of phobias and via the concept of the emotional bonding that a soldier has for the fellow soldiers in his unit. Evacuating the psychiatric casualty too far away from his unit weakens this bond and the relative security from the heat of the battle increases his fear of injury and death. In this case study, both concepts apply for this patient, although less so for bonding as there was no battle to talk about. Even in civilian psychiatry, exposure, via Proximately given treatment, for non-combat acute PTSD is also deemed to be a critical part of the total treatment.^{14,17,18} This patient was not immediately returned to his unit after his first consultation, as this author has deemed it to be too big a step and too anxiety-provoking to do so in view of his having sampled the relative security of home. Thus he was given the homework to "return" to his unit in imagination before he physically returned to his unit after his second appointment. The successful outcome of this case demonstrates that this flexible variation is still effective.

The principle of Expectancy sets a clear, standardized and unbiased therapeutic goal for all Combat Stress casualties, who will be informed and thus will be fully aware of the therapeutic goal. Maintaining the atmosphere of Expectancy everywhere, from the casualty station to the casualty's parent unit is of paramount importance not only in the recovery process of the psychiatric casualty but also in his successful assimilation back into his unit.¹⁸ An essential part in helping the casualty to expect recovery and return to normal duty is to inform the casualty that it is the battle situation that is abnormal and that it is normal for him, a normal person, to react to the abnormal situation. From the very first consultation, this patient was reassured that he is a normal person reacting to an abnormal experience. He was also informed that he is expected to recover fully and return to normal duties. This author attributes the patient's quick return to his medical centre, after only 2 consultations, to the successful application of this principle of Expectancy. This is to be contrasted with the multiple counselling sessions that his unit medical officer gave him which still fail to return him to duty.

The principle of Simplicity was discovered as far back as the First World War. Simple methods of treatment include catering to the casualty's physical needs, such as food, water and rest, and emotional needs, such as reassurance, recounting his traumatic experience and rehabilitation. In fact a paradox has been discovered in the treatment of Combat Stress casualties; that the more they are treated like hospital patients, the worse their condition becomes and the less likely they are to recover.¹⁵ Medication, symbolic of illness, reinforces 'the sick role and thus contradicts the reassurances to the combat stress casualties that they are normal individuals reacting to an abnormal experience. The use of medication is therefore strongly resisted. The same principle was applied in the management of this patient and he recovered without the need for medication. This is in contrast to the use of medication in a case of delayed onset PTSD described by Lim.¹⁹ Friedman²⁰ had concluded that drug treatment is never sufficient to alleviate the suffering in PTSD and that pharmacotherapy is primarily useful as an adjunct to psychological (intrapsychic and/or behavioural) treatment of PTSD. Davidson¹⁸ opined that pharmacotherapy is probably most effective when administered as part of a broad based treatment plan. Bisson and Jones¹⁷ have commented that exposure therapy should be the first line treatment in PTSD and medication be reserved as second line treatment or used to treat a coexisting problem such as depressive disorder.

Besides dealing with the psychological impact of the traumatic experience on this patient, this author agrees with Spragg²¹ that whatever the primary method of treatment may be, it is essential to understand that

nothing will help if the psychological needs of the patient are not taken into account. This patient's other psychological needs, including coming to terms with his mother's death, the loss of his girlfriend and the issue of shame, were all dealt with too.

This patient experienced maternal deprivation during the first 2 years of his life. Although his mother tried to compensate for it subsequently, she could not totally remove the effects of his early maternal deprivation. This has resulted in his being "emotionally weak", manifested in his apparent difficulties in adjusting to change. The sudden loss of his mother led to unresolved grief which resulted in his blaming himself for not being present to save his mother. This misplaced sense of irresponsibility was reactivated when his colleagues chided him for not resuscitating the casualty. The unresolved grief has also led him to fear further losses of other people of importance to him. This led him to rationalize that giving up his girlfriend was an altruistic act when he was actually preventing his girlfriend from becoming too important to him, thereby eradicating the possibility of losing another person close to him. Brief Dynamic Psychotherapy has helped him to come to terms with the losses, gain insight and become more resilient in dealing with future stressors. Admittedly, in times of war, dealing with psychological issues other than the traumatic experience may be considered an ill affordable luxury, such that the principle of Superficial management of BICEPS¹⁴ (i.e. no attempt should be made to explore deep unresolved conflicts) would have to apply.

The issue of shame arose from a sense of inadequacy invoked by his colleagues' reproach for his failure to initiate cardiopulmonary resuscitation for the suicide victim, who, in most likelihood, was already dead by the time he was discovered. Stone²² had commented that even in natural disasters or in other situations in which no blame can be attached, there is a kind of shame engendered by the revelation of the self's inadequacy for not coping with the requirements of a capricious universe.

For military psychiatrists to manage PTSD patients using Combat Stress treatment principles during peacetime certainly is not a luxury nor a passive indulgence. Other than wartime experience, military psychiatrists need a chance to translate theory into practice. The closest approximation to treating Combat Stress casualties would be to apply the Combat Stress treatment principles to treating non-combat acute PTSD patients, though these by themselves are uncommon enough. This author, being an ex-military psychiatrist, would like to make some proposals. Military psychiatrists must be on a lookout for PTSD patients. Whenever opportunities arise, such as a fatal training accident, every effort must be made to screen all the survivors who are in-

volved and all the witnesses. Psychiatric emergency rescue teams, similar to those described by Peebles,¹ comprising mental health workers, which include military psychiatrists, psychologists, counsellors and paracounsellors and unit officers, should be despatched to the scene to perform the screening. Those manifesting signs of PTSD should be managed by the military psychiatrists. Those showing signs of stress reaction can be managed by counsellors, psychologists or unit medical officers. Those who appear minimally affected or equivocal cases should be followed up by paracounsellors or unit officers, as delayed presentation of PTSD is a possibility. Screening can take the form of a debrief, for which FitzGerald et al²³ have found to be also a form of therapeutic intervention. Vargas and Davidson²⁴ have proposed that rating scales be applied to obtain a baseline before treatment. They have suggested certain rating scales, both observer-rated and self-rated, for reference, which can be used as a starting point for the military psychiatrists to find one suitable for our local context.

Conclusion

This case study has demonstrated how Combat Stress treatment principles have been successfully applied to a non-combat acute PTSD patient. The applicability of this treatment protocol only underscores the potential pool of patients available to military psychiatrists to hone their skills to treat combat stress casualties. This highly efficacious method of treatment has shortened the duration of his symptomatology such that the case almost did not meet Criteria E of the DSM IV diagnosis of PTSD. It is however not the aim of this article to debate whether Criteria A should have pre-eminence over Criteria E of the DSM IV criteria for PTSD. In order to apply the principle of Immediacy, the detection of PTSD cases is of paramount importance and cannot be overemphasized. Thus this author recommends that systems be built in place to respond to events that may generate cases. Protocols would have to be drawn up to deal with the various categories of those affected to varying degrees. Helpers ranging from the various categories of mental health workers, to unit medical personnel, to the officer corps, need to be informed and trained to detect and deal with soldiers who have been exposed to traumatic events and are at risk of developing PTSD. The last thing a nation needs is to have unknown numbers of dormant cases of PTSD in its armed forces waiting for the trigger to activate the condition.

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