

# An holistic view of post-traumatic stress disorder

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## Introduction

Post-Traumatic Stress symptoms account for an increasing number of presentations to health service facilities by Australian Defence Force personnel. The cost of management is absorbing a significant proportion of the defence health budget, much of it expended on external health care providers.

The recent disproportionate increase in mental disabilities, such as Post-Traumatic Stress Disorder, compared with war inflicted physical injuries is of significance and has serious implications for the ADF and its role as an effective fighting force.

This paper will examine some aspects of the diagnosis and management of PTSD from the perspective of a general clinician who has been an ADF medical officer since 1980 and undertaken several deployments.

## Service in the Australian Defence Force

Military service by definition is inherently dangerous. Implicit in the defence force work contract for uniformed personnel is an acceptance that there will be exposure to environmental hazards, potential injury, disagreeable sights and long working hours. On deployment this is compensated by tax-free pay and campaign allowances which are more generous than those offered by our coalition partners; for example, Britain and New Zealand do not provide tax-free pay to their personnel on deployment. All ADF personnel who deploy on war-like service are volunteers.

Strict ADF-imposed caveats on limiting exposure to hostile activity result in only the Special Operations Task Group component of Australian contingents being involved in a traditional war fighting role. About 80% of contingent personnel provide support and logistics.

Casualty rates in the Australian forces have been declining since World War 1 – 60,000 killed in WW1, 27,000 killed in WW2, 300 killed in Korea, 500 killed in Vietnam, nil killed in the Gulf War 1991, 1 killed (accidental) in Somalia, nil killed in Rwanda, 2 killed (accidental) in E. Timor, 1 killed (accidental) in Kuwait, 1 killed (accidental) in Iraq, 1 killed (accidental) in the Solomon Islands and 11 killed in Afghanistan.

On a pro rata basis, ADF casualties are light compared with those of our allies; for example, Canada has had 140 killed in Afghanistan while Britain has had over 250 killed.

## The Diagnosis of Post-Traumatic Stress Disorder

Post-Traumatic Stress symptoms may manifest in various ways, some obvious such as depressed mood or poor workplace performance, while other presentations may be more subtle. The first indication may be raised by the results of the Kessler-10 or Post-Traumatic Check List-C questionnaires conducted at Return to Australia Psych. Screening or Post-Operational Psych. Screening at three months.

The subsequent referral to a civilian psychologist or psychiatrist often confirms the diagnosis in accordance with the Diagnostic Statistical Manual of Mental Disorders (DSM) symptom criteria. Relevant pre-morbid aspects of some of these members, for example, mood disorders, alcoholism, disciplinary problems, incompatibility with service life, pre-existing marital disharmony – are rarely considered. Such revelations might detract from a formal diagnosis of PTSD. In some personnel with no exposure to potential harm a PTSD diagnosis is possible as “it may be triggered by memories conjured up by what others have mentioned – a recognized phenomenon in some individuals with PTSD” (Paljakka BOI, 2008) – so called vicarious PTSD.

Of concern is that a number of Returned Services League pension officers, acting as de-facto clinical consultants, determine a diagnosis of PTSD from their checklist before the member has been formally assessed. Consequently some members are insistent that they have PTSD from the outset and will not accept another diagnosis. It could be construed that these members may have been coached by their colleagues or advisers, especially if their Department of Veterans' Affairs claim forms have quotations from the DVA Statement of Principles or the DSM .

A friend of mine for over 30 years (ex-ADF) recently showed me his psychiatric report confirming PTSD regarding an alleged fatal helicopter crash that he witnessed. He admitted that the incident was a complete

fabrication and stated to me, and I quote, "Mate, the psychs will believe anything".

### Management

Once the diagnosis of PTSD is made the patient enters a program consisting of counselling, cognitive behavioural therapy, psychiatric consults, sometimes anti-depressant medications, in-patient treatment etc.

In some treatment programs the reinforcement of a victim mentality with a prominent focus on 'self' can impair a member's insight and distort reality. Albert Ellis' Catastrophe scale, as part of a behavioural therapy approach, is an old way of re-introducing some perspective to patients, for example, "you have these distressing symptoms but are they as bad as what happened to the people you saw who were injured, mutilated or killed?" None of my PTSD patients seem to have been made aware of it. Some members embark upon the convalescent leave "treadmill", becoming disengaged from their workplace and disinclined to return to work, eventually being medically discharged. The administrative burden on a unit with a member on prolonged convalescent leave, who is unable to be gap-filled, can be significant. An integral part of long term management is the award of a life-long DVA disability pension, which several members have admitted to me was their motivation for seeking a diagnosis of PTSD.

My first PTSD patient in 1994 was discharged from the ADF as totally and permanently incapacitated at the age of 31 and thereby unable to engage in more than 10 hours of paid work a week for the term of his natural life. Despite having a pre-morbid personality disorder (nickname "the angry ant") the treating psychologist did not acknowledge his anti-social tendencies as a pre-disposition and attributed an array of inconsistencies in his story to "rationalisation". It was interesting to observe the immediate lifting of his depressed mood on receiving his TPI determination. This outcome was inappropriate for a healthy, muscular man capable of working a normal week and he was subsequently investigated for breaching his work restrictions.

### Discussion

The current broad definition of PTSD, which not only includes the direct threat of harm but also the perception of threat of harm and the hearing of stories of harm (vicarious PTSD). It appears unsustainable in a volunteer Defence Force which will of course be placed in such a position.

The subjective nature of the history and symptoms requires an accurate assessment to determine authenticity, which is usually beyond the capabilities

of civilian psychologists and psychiatrists who cannot conduct a critical analysis. Some specialists appear too willing to confirm a diagnosis of PTSD mainly on the basis of a check list of symptoms and an unverified history direct from the patient.

Some diagnostic reports display a credulous naivety that would be amusing were the consequences not so serious, as there is sometimes considerable embellishment by the member. One report I recently read from Camp Victory, Baghdad in 2007 (I was present during the stated period and remember the person) sounded more like the Battle of the Somme - an exaggerated, disingenuous story recorded as fact. The psychiatrist confirmed PTSD although I remain sceptical, as the member had pre-existing issues and was not a stellar workplace performer.

It appears that, not uncommonly, psychological symptoms in conjunction with a history of operational deployment can lead to a diagnosis of PTSD.

In a few cases that I have part-managed, my impression was that the member satisfied the DSM criteria for malingering rather more than PTSD, so as to avoid responsibility for their actions; for example, dereliction of duty, insubordination etc. In some situations I know that PTSD has been used as a legal defence before a Defence Force Magistrate, as opposed to being used in mitigation. Such behaviour can be detrimental to Unit morale and create antagonism towards the member.

I believe that a diagnosis of PTSD should be based on a comprehensive, holistic assessment of the patient with the diagnosis arrived at by consensus among the various professionals involved in management. The referring primary care physician and unit medical assistants often have valuable knowledge and insight regarding the member.

A medical tribunal, with military representation, would be an appropriate body to make a comprehensive assessment of a member as access to all medical, service and Unit records would be possible and so allow composition of an accurate profile.

If the K-10 and PCL-C questionnaire results are to be believed, then it appears that successive generations of Australians are becoming less able to tolerate the demands of war-like deployments. At the 2008 AMMA Conference in Hobart, Dr. Tyler Smith PhD reported that the US Navy had the lowest reported incidence of PTS symptoms in the US Forces. In contrast, Australian data suggested that the RAN had the highest reported incidence of PTS symptoms of all our 3 services.

This discrepancy in findings between two allied navies is disturbing, as it suggests either diminished mental

resilience in the RAN or low threshold diagnostic criteria in Australia.

The fact that the RAN contingent to the first Gulf War (16 Jan – 28 Feb 91) has over 20% of those personnel on mental disability pensions, mainly for PTSD, despite firing no weapons offensively, sustaining no battle damage and taking no battle casualties, is of serious concern. Likewise the 2nd Australian contingent to Rwanda, 20% of whom observed the Kibeho massacre, now has over 80% of the contingent personnel on mental disability pensions, mainly for PTSD. I understand that some claimants were on leave in Nairobi, Kenya (800 kms away) during the incident. Some of the pension recipients voluntarily deployed to East Timor on war-like service five years later enabled them to submit further DVA claims for exacerbation of their PTSD.

During March 2003 I was presented with an interesting situation when a member of my ship's company informed me that he was in receipt of a DVA pension for PTSD from a helicopter crash 16 months previously, from which he escaped with a minor injury. He admitted that some of his work onboard involved visiting other ships by helicopter. I asked him how he reconciled this inconsistency and he stated to me, and I quote verbatim, "Sir, you get over it". A significant comment from a pensioner who had volunteered for a war-like deployment.

My personal impression is that many of those with true PTS symptoms have a short to medium term condition that requires clinical management in isolation from the financial inducement to delay recovery offered by a DVA pension (in young soldiers with 60 years of life ahead this could amount to over a million dollars). RSL pension officers generally emphasize compensation aspects and, consequently, some members have an unrealistic sense of entitlement.

I do not dispute the diagnosis of PTSD but believe that it is often diagnosed in preference to other conditions which do not gain compensable DVA recognition.

A life-long disability pension is inappropriate in the majority of PTSD patients as most do not have a life-long disability, although awarding a pension can have a dramatic therapeutic effect. An apparent psychological disability, diagnosed on subjective criteria, should be confirmed as life-long from a retrospective viewpoint. In contrast, a significant physical injury with objective signs can be determined as life-long from a prospective viewpoint.

Unfortunately there appears to be developing some disturbing similarities between repetitive strain injury of the 1980's and PTSD. Such conditions, diagnosed mainly on subjective parameters and questionnaires, are prone to manipulation which can result in unreliable findings determined by the members' desired outcomes.

### Conclusion

Contrary to current opinion, I believe that the prevalence of PTSD in the ADF is overestimated and that the number of genuine cases is significantly less than believed. The propensity to diagnose PTSD in preference to other conditions that might be the cause of members' symptoms and behaviour is of serious concern in that appropriate management, medical or otherwise, may not be implemented.

ADF morale is likely to deteriorate in the long term and resilient personnel become disillusioned if PTSD becomes the primary focus of the ADF Mental Health Strategy. An independent, financially disinterested Commission of Inquiry should conduct a review of all aspects of diagnosis and management of PTSD in the ADF, possibly as a sequel to the Dunt Inquiry. Widespread ADF participation should be encouraged.

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