JOINING FORCES

VOLUME 6 ISSUE 1 | *RESEARCH NEWS YOU CAN USE* | *WINTER* 2002

In the present war on terrorism, it is important for us to be alert to the experiences of our clients, their families and our communities. Therefore, in this issue we abstract two articles on post-traumatic stress disorder. One is an editorial written by Robert Ursano, MD, the Chairman of the Department of Psychiatry at the Uniformed Services University of the Health Sciences (USUHS), and the principal investigator of the Family Violence and Trauma Project (FVTP). The second article is an overview of PTSD by Rachel Yehuda, PhD. We also interviewed Dr. Ursano about PTSD and other responses to traumatic events. We conclude with information about needs assessments and Centers of Excellence.

IN THIS ISSUE

POST-TRAUMATIC STRESS DISORDER

Since September 11th, there have been a multitude of stories written about the perpetrators, victims, rescuers, and other groups of responders. With the easy availability of print and electronic media, this wealth of information can become voluminous. On one hand, this is good in that people can document their involvement and feelings. However, it makes it very difficult to keep up with the flow of words and to separate the high quality articles from those that are of lesser quality and interest.

In her review article in the New England Journal of Medicine, Rachel Yehuda, PhD, summarizes what is known about PTSD from three approaches: epidemiological, psychological, and biological. She also discusses the definition and current treatments. PTSD is defined by the existence of a stressor (according to the diagnostic criteria, the event must have the capacity to evoke fear, helplessness, or horror in response to a threat of injury or death) and three personal responses to that stressor. These are: (1) a re-experiencing of the event (through unwanted thoughts and dreams or nightmares), (2) avoidance of reminders of the trauma (including persons or thoughts associated with the event or places, such as avoiding the street corner where you once had an automobile crash), and, (3) hyperarousal (such as the inability to sleep, poor concentration, and being "keyed up" or jumpy).

Clinicians who treat patients with possible PTSD have to be alert for both the stressor criteria (often omitted in the practice of inquiring about a patient's symptoms and history) and the presence of other disorders that are concurrent with PTSD or may mask it (such as another anxiety disorder, depression, or substance abuse). The author notes that most primary care physicians should be able to identify PTSD; however, it may be missed if a trauma is not suspected or inquired about. Sometimes physicians are reluctant to inquire about traumatic abuse (as FAP personnel are aware, often this includes family violence). A complete table of the defining characteristics of PTSD and its three subtypes are included in the article.

Dr. Yehuda's article summarizes the epidemiology of PTSD, refers to the origin and the distribution of PTSD, what factors seem to be associated with it, and how often it occurs in men and women. Prior to September 11th, 5-6% of men and 10-14% of women had had PTSD sometime in their lifetime. (This is called the lifetime prevalence.) The events that most commonly give rise to PTSD are interpersonal violence, exposure to life-

Continued on page 2

TABLE OF CONTENTS

POST-TRAUMATIC STRESS DISORDER 1

DR. URSANO'S EDITORIAL COMMENTS 2

INTERVIEW WITH DR. URSANO 3

ACS NEEDS ASSESSMENT 5

CENTERS OF EXCELLENCE 6

Continued from page 1

threatening events (such as combat and motor vehicle crashes) and disasters (fires, earthquakes, and hurricanes). Interpersonal violence seems to evoke PTSD more often than the others. It is unclear whether the higher rates of PTSD in women are due to their vulnerability to PTSD or whether men and women experience events differently. This question requires further psychological and biological research.

The psychological aspects of PTSD include how a traumatic

JOINING FORCES

Editor-in-chief
James E. McCarroll, Ph.D.
Email: jmccarroll@usuhs.mil

Editor
John H. Newby, DSW
Email: jnewby@usuhs.mil

Data Manager
Zizhong Fan, B. Med, MPH
Email: zfan@usuhs.mil

Copy Editor
Melora Sapp, B.S.
Email: msapp@usuhs.mil

Joining Forces is a publication of the Community and Family Support Center and the Family Violence and Trauma Project at the Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland 20814-4799.
Phone: (301) 295 – 2470

The fear response has a biologic basis, but it is also affected by a person's subjective experience and includes such personal variables as past experience with the same or other traumas. It is difficult to separate the psychological aspects of PTSD from the biological. For example, experiencing trauma challenges a person's sense of safety and recovery involves confronting the event and its aftermath in such a way as to increase the person's resiliency. The body's biological response to a traumatic event may perpetuate the fear and interfere with the recovery. For example, the biologic aspect of the fear response may interfere with the person's mobility or other coping responses, which may then perpetuate avoidance behavior. She notes that regardless of the emotional response (e.g., horror, fear, sadness, guilt), recovery requires acknowledgment of the changes that have occurred since the traumatic event.

Without going into the detail that she presents regarding brain structures and pathways, her presentation of the biology of PTSD may be summarized by her note that the data support the notion that the development of PTSD is facilitated by a failure to contain the biologic stress response at the time of the trauma. This results in a cascade of physiological alterations that lead to intrusive recollections, avoidance of reminders, and the hyperarousal characteristic of PTSD. She also notes that studies have shown that persons with PTSD have a greater activation of the sympathetic nervous system (the fight or flight response system) than those without such reactivity.

The treatment of PTSD often includes both counseling and medication approaches. She describes methods of counseling persons with PTSD both by the general practitioner and by the specialist. Education and an approach that will promote a feeling of safety and support are likely to be helpful. The counselor emphasizes that the patient's response is a reaction to overwhelming stress and not a character flaw or a sign of weakness. This approach can also help prepare a patient for service from mental health providers. Specialized techniques include having the patient recall fears and emotional responses to the traumatic event in a structured format without becoming overwhelmed again.

Medications that have been used for PTSD include a variety of anti-depressant agents. Some drugs should be avoided. Medication therapy requires close physician monitoring.

Yehuda, R. (2002). Post-traumatic stress disorder. New England Journal of Medicine, 346, 108-114.

Dr. Ursano's Editorial Comments

Dr. Ursano provided an editorial to the NEJM on how the feelings and reactions of persons affected by the 9-11 attacks relate to post-traumatic stress disorder (PTSD). He also provided some

Continued on page 3
Continued from page 2
insights on patient management and offered some responses to persons seeking assistance for distress related to traumatic events.

Dr. Ursano's editorial is directed toward primary care physicians and places the events of

9-11 in the larger context of the impact of other recent terrorist events. In the Oklahoma City bombing 44% of adults reported one or more substantial symptoms of stress, emphasizing the importance of the degree of exposure and PTSD symptoms. Early approaches that can be helpful include helping patients identify the cause of the stress, and limiting further exposure (such as not watching television), and maintaining regular biological rhythms (e.g., eating and sleeping).

Other disturbances can also occur following exposure to a traumatic event. Among these are pathologic grief, unexplained somatic symptoms, depression, sleep disturbance, the increased use of cigarettes and alcohol, and increased family conflict and family violence. If any of these symptoms appear, the role of trauma should be explored. For patients with somatic symptoms, the symptoms may relate to signs of anxiety or depression. Conservative management for these patients includes education and reassurance, the core medical treatment of somatic and psychological symptoms after trauma. A discussion of specific worries can initiate the process of normal stress resolution or clarify the need for further referral. Other aspects of the normal process of recovery include talking with others, learning new coping strategies, and seeking help. Withdrawal may indicate the presence of depression and call for further evaluation and treatment. Further comments are directed toward the health of the U.S. medical system and what might be the effects on it from another attack that produces mass casualties. Importantly, resiliency is the rule in the long run after exposure to trauma, but physicians and other healthcare professionals can help their patients cope with the horror of traumatic events and acts of terrorism.

Ursano, R. J. (2002). Post-traumatic stress disorder. New England Journal of Medicine, 346, 130-132.

Joining Forces' Interview with Dr. Ursano:

Witnessing horrific and traumatic experiences can result in the development of post-traumatic stress disorder (PTSD) or other stress-related symptoms. We questioned Dr. Robert Ursano (RU) about such responses to trauma related to September 11th.

Editor: Do many individuals develop PTSD following incidents such as the terrorist attacks on September 11th?

RU: People experience a number of symptoms and normal responses to such disasters. There are significant changes in their views of safety and other aspects of their daily lives. Most people do quite well. However, some individuals will have a more difficult time and may develop PTSD.

Editor: Do particular individuals develop PTSD-related problems?

RU: It is hard to know who will have difficulty. At most risk are individuals directly involved or those with family members or friends who are killed or injured.

Editor: We saw those pictures on television over and over. Can watching television images of such traumatic events lead to PTSD or other emotional problems?

RU: Televised showings of traumatic events can have a negative effect. It can also provide healing by providing information to help individuals understand what events are actually occurring. It is very difficult seeing life threatening events on television and possibly identifying with the victims.

Editor: What symptoms occur with PTSD?

RU: There are several things that occur. Initially, one may experience a haze or forgetfulness. Later we may see intrusive thoughts, images, memories, and even nightmares. Sometimes, people want to remove themselves from reminders of the event and they get jumpy if they hear loud noises. There may also be increased depression, feelings of sadness, irritability, and family violence.

Editor: Are there any specific

Continued on page 4
Continued from page 3
physical problems that may accompany PTSD?

RU: Yes, one is the feeling of being tired. It often comes from staying up late, from not having the right amount of food, from not taking care of oneself, and from disrupted sleep. Another physical symptom is changes in normal patterns of sleeping and eating. The third is that individuals can experience more aches, pains, and multiple physical symptoms

Editor: Are there things that would be of help to individuals who have problems associated with traumatic events?

RU: When threats to life occur, it is important for individuals to have an opportunity to describe their fears and tell their story. If their symptoms are severe, they should be referred to a physician or another health care pro-fessional. Regularizing eating and sleeping patterns can also be beneficial, as well as, limiting ones exposure to reminders of the trauma that may be seen on television, heard on the radio or read in newspapers. It is important to take a break from the trauma or reminders of it. Vacations, long walks, and relaxation techniques can also be helpful.

Editor: Sometimes people simply want to withdraw and be by themselves, could you comment on that?

RU: Isolation, limited interpersonal interaction, and withdrawal related to traumatic events can lead to depression and other more problematic symptoms. Relating to others facilitates many ways of healing. For example, talking about the event can be helpful and it is important to be with others who can watch you and refer you for help if you need it.

Editor: It is hard to find someone who is not very angry about the events of September 11th. What is the role of anger in all of this?

RU: Anger is an expected and important component of all disasters and it seems to grow. However, the anger should not be misdirected. Anger should be directed towards something that is useful. There have been several incidents where misdirected anger has led to the stigmatization of groups.

Editor: A lot of children saw the planes hit the World Trade Center and saw pictures of what happened at the Pentagon. How do we help children who have been affected by what they saw in the news? How can we help them understand the tragedy?

RU: During times of a disaster, children are a great concern to us. Children are very sensitive to being exposed to such events. I am sure that many were extremely frightened seeing people falling from buildings or even finding out that adults can cry. It is important to listen to children's stories to find out their fears and worries. Children need to have their normal daily patterns re-established. School is a significant part of the normal experiences of children so going back to school can be a vital part of their recovery. Reading familiar stories to them may also be helpful. Let children know that they are not in the location where the events occurred and that there is no specific threat to them.

Editor: We heard numerous comments from local and national leaders in response to 9-11, what is your assessment of what they have said or have done?

RU: A role of leadership is to reassure us and develop a template by which we will recover. It has been called grief leadership. That's the manner in which leaders guide us through the process of grieving by demonstrating their own grief. When that happens, it lets the rest of us know that it is OK for us to have similar feelings of grief. One of the most immediate responses to terrorism is the alteration in our feeling of being in a safe environment. It is vitally important for our national and local leaders to concentrate on restoring a sense of safety. When these feelings are restored, we move forward in our recovery.

Editor: There is an increased amount of patriotic songs and displays of the flag. What role do they play in helping us to recover from the terrorist attack?

RU: The flag and songs are significant examples of how memorials and symbols assist us in the recovery process. Symbols have a special meaning during times of disaster and can provide encouragement and restructure our responses. Participating in

Continued on page 5
Continued from page 4
symbolic events lighten loads of discontent and worry because one feels that others are in the same situation. One of the most significant parts of a disaster experience is to bring communities together and re-awaken feelings of camaraderie, caring, and love. Trauma is often experienced as both an opportunity and responsibility to reevaluate our values and to examine what we think is important in life.

Editor: Any concluding comments about people who are having difficulty.

RU: I am sure that most people will do well over time. Everyone is experiencing alterations in their sense of safety, changes in their

concern about family and friends, and concerns about traveling. I would be very concerned about issues of isolation, withdrawal or experiences of hopelessness. They are triggers that indicate the need for professional intervention.

Thinking About Army Community Service Needs Assessment

The Family Violence and Trauma Project (FVTP) and Cornell University Strong Soldiers, Strong Families staff will assist Army Community Service (ACS) directors in formulating and conducting a needs assessment during the coming year. A pilot program will be developed and, based on the results, a procedure will be fielded to enable a greater number of ACS sites to administer the needs assessment. These matters are still under discussion and a definitive plan will be presented at a later date. However, we have conducted a brief literature review on needs assessment studies and present some thoughts on the nature of needs assessment and how one might think about approaching the process.

In general, a needs assessment is a procedure to match resources to the needs of the population being served. Since ACS is in the human services field, a needs assessment of all of its programs could become extremely complex if reasonable limits are not imposed on its goals and objectives.

ACS has many programs: mobilization and deployment support (MDS), Army Family Team Building (AFTB), relocation readiness service, financial readiness, employment readiness, exceptional family members, volunteers, Army Family Action Plan, family advocacy, and transitional compensation.

MDS provides support services during all phases of deployment to all eligible family members. AFTB is an educational program to promote personal and family readiness. Financial readiness teaches soldiers self-sufficiency in their financial affairs. Employment readiness helps soldiers who are leaving the Army who may have employment problems associated with their relocation and transition. The Exceptional Family Member Program is mandated to support families with special needs. The volunteer program augments staffs and expands program capabilities through individual donations of time and work. The Army Family Action Plan (through efforts at the installation level) identifies services and initiatives critical to improving standards of living in the Army. The Family Advocacy Program prevents and treats child and spouse abuse by providing a variety of services to strengthen families.

Why should you conduct a needs assessment? Needs are always greater than resources. This is one reason for the existence of governments and bureaucracies to allocate resources to community needs. Another reason is to monitor the processes of change within communities served by Army programs. The Army can change in a variety of important ways depending on such factors as the economy, changes in American society, changes in laws and regulations, education, and demography (age, race, and sex). Therefore, a program that was tailored for a group five years ago may not currently serve that same population. In a large bureaucracy like the Army, people who provide funding (Congress, DoD, the Army) are a long way from those who implement and participate in programs. Therefore, connecting these two mechanisms in a timely fashion is often a challenge.

What are the methods one might use in a needs assessment? The primary methods are surveys (via paper and pencil, or electronic media), interviews (in person or telephone, individual or group), and the collection of data from other sources that relate to the program. To achieve some sense of reliability and validity, data should be gathered through a

Continued on page 6
Continued from page 5
process that allows every person the same opportunity to be selected. This is extremely difficult to do in practice because of the difficulty in (1) identifying members of the population, (2) contacting them, and (3) obtaining valid data. Rather than having a random sample from which one might draw conclusions about the population (within reasonable limits), you may have to use a convenience sample. Regardless of the approach, a needs assessment must be done systematically.

What are the measures that you use? Can you ask just a few questions that will give you meaningful data or do you need to ask many questions? Obviously, there is a tradeoff between collecting as much data as the researcher needs and the time participants want to engage in the research. Is there a standard that you can use to measure effectiveness? Is a program that

reaches 10% of your available population with a 90% level of satisfaction any better or worse than a program that reaches 50% of the population with a 50% satisfaction level?

Surveys and interviews could be done with many different groups of people to gather data for the needs assessment. In the military community, one could talk to commanders, program managers, participants, and non-participants. Outside the military, one could talk to providers of civilian programs which are frequented by military families and other collateral resources.

In addition to the afore-mentioned question, the design of a needs assessment raises several other questions. What problems/ issues occur when trying to match resources to needs? What measures will you use?

- Do you only focus on persons who have participated in programs or the entire post?
- Do persons with the greatest need participate in the program?
- Can the program meet participants' needs without stigmatizing them?
- Is the program available at a time when individuals can participate?
- Are efforts made to periodically or continuously recruit individuals who might benefit from the program?

It is likely that the pilot needs assessment that will be developed will be a balance of the responses of individual program participants, program managers, community leaders, and data from existing records. ACS directors will then be able to collect and interpret assessment data in a way that will benefit their installation.

We would appreciate your reactions and thoughts about needs assessment in your community.

Centers of Excellence

Actions are underway by the Community and Family Support Center to establish Family Advocacy Program Centers of Excellence (FAPCOE) to strengthen and preserve families. FAPCOE will be committed to providing the highest quality of family advocacy research and intervention services, be primarily established on a regional basis, and serve as a hub for FAP training and consultation. Installations are eligible for the FAPCOE designation if they demonstrate the potential for developing and evaluating the effectiveness of an innovative and focused area of FAP prevention, treatment, or research. A research and evaluation component is required of a FAPCOE. However, the research component can be added after the FAPCOE is established. Funds to establish FAPCOE will be provided by CFSC.

Guidelines have been developed for the submission of FAPCOE applications. For a copy of the guidelines, suggested areas for research/interventions, or more information, contact Dr. John Newby at 301-295-6506, email JNEWBY@USUHS.MIL or FAX 301-319-6965. You may also contact LTC Yvonne Tucker-Harris, the HQDA FAPM, at 703-681-7393, email Yvonne.Tucker-Harris@cfsc.army.mil FAX 703-681-7239.

Department of Psychiatry.