

Frequently Asked Questions About Post Traumatic Stress Disorder

Q1. What is Post Deployment Health Assessment?

A1. Post Deployment Health Assessment or PDHA is the military's global health screening that occurs when a unit or service member returns from an overseas deployment.

Q2. What is Post Deployment Health Reassessment?

A2. The Post Deployment health Reassessment or PDHRA, is a new part of the military force health protection program. It is a health screening tool used 3-6 months following redeployment or return of service members from overseas deployment. PDHRA extends the continuum of care for deployment related health concerns and provides education, screening, assessment and access to care.

Q3. What is Post Traumatic Stress Disorder, and who is most susceptible to it? How is it different from routine combat stress?

A3. Post Traumatic Stress Disorder, commonly referred to as PTSD, is a condition where the war events are re-experienced and continue to affect a person after they return home. Symptoms of PTSD include nightmares, flashbacks, feeling revved up or irritable, feeling numb, and feeling anxious or avoiding any reminders of war. In contrast, combat stress reactions are short lived reactions to stress in the combat zone. While the symptoms can be similar, post-traumatic stress disorder is a longer term condition characterized by various symptoms that can interfere with social or work functioning.

Q4. How many Soldiers have been referred for mental health evaluations and how does that compare to diagnosis?

A4. About a third of all soldiers who return from OIF have received mental health care in the year after return. This includes screening, prevention, and treatment services. Most of these Soldiers do not receive a diagnosis of a mental health problem, and many of these soldiers were evaluated as response to PDHA screening. Our data suggest that 10-15% of post OIF soldiers are at risk for PTSD, meaning they met screening criteria for PTSD. The most common diagnoses include adjustment reactions, depression, anxiety disorders and alcohol and substance related problems. Reporting symptoms does not mean that the Soldier has a psychiatric disorder. More commonly, Soldiers experience short-lived and normal reactions that improve over time. However, soldiers may need help if symptoms persist or interfere with work or social functioning.

Q5. Is seeing a mental health professional a career killer? Is it confidential?

A5. Seeking medical assistance from a mental health care provider is not a career ender. The Army is very proactive in encouraging soldiers to get the help they need, and most Soldiers diagnosed with PTSD are treated and can remain on active duty. Today, we have a much better understanding of the psychological effects of war. Soldiers are being trained to look out for the mental health of their buddies in the same way that they look out for their physical health, and leaders are being trained to encourage soldiers to get help. The message is getting out that coming in to get help early is the best way to avoid long term problems. Our intention is to return Soldiers back to duty. Reference confidentiality, medical professionals keep everything as discreet as possible. However, there may be times when a command needs to be advised about a Soldier's medical care. This usually occurs when a Soldier is suicidal or homicidal.

Q6. What is the importance of Mental Health Advisory Teams I and II?

A6. They're groundbreaking really. These teams deployed to Iraq to assess how troops were doing on the ground and how well behavioral health services were working in theatre. Extensive reports were produced that led directly to changes in the way services are delivered in the combat zone. The importance of MHATs is that this is the first time we've sent researchers into a combat zone and that we used the findings to make changes in the way we deliver care to the theater. For example, MHAT I found patients found it difficult to get to

practitioners. We further disbursed our practitioners to help Soldiers so that they would not have to travel as often or as far for care.

Q7. Are some Soldiers more susceptible to mental health disorders than others?

A7. There are many things that can contribute to susceptibility, including genetic history (whether there is a family history of mental health or substance abuse problems) and prior trauma. In general, those with prior psychiatric history may be more susceptible to deployment related mental health diagnosis. Data shows exposure to combat/firefights may be more associated with PTSD symptoms. MHAT II data showed that women are at about equal risk for mental health diagnosis as their male counterparts.

Q8. What kind of mental health difficulties might a service member experience after returning from OIF or OEF deployments?

A8. Reconnecting with families, nightmares, alcohol and/or substance abuse, aggression, hyper vigilance.

Q9. How can a service member tell if he or she should seek medical or professional mental health care? And, when is it better to see a chaplain vs. a social worker vs. a psychologist vs. a psychiatrist?

A9. If symptoms are interfering with functioning in some way or if symptoms are leading to dangerous behaviors or thoughts then they should seek help. It really doesn't matter a lot who they see first. Chaplains are often the best first line person to go to because most battalions have chaplains know the soldiers and units well. Social workers are more often involved in partner relation and family problems.

Q10. Typically, what occurs when a Soldier seeks mental health care in the military medical system?

A10. similar to civilian practice settings; they can receive individual or group counseling. Medications may be prescribed.

Q11. Are most mental health issues that result from deployments treatable or curable?

A11. Mental health issues resulting from deployment are treatable and usually curable. We use a combination of psychotherapy and medication, as appropriate.

Q12. How are alcohol abuse and other reckless behaviors such as driving fast or drinking and driving associated with mental health—especially following deployments?

A12. Soldiers may use alcohol frequently to calm down. Soldiers with PTSD symptoms may use alcohol to try to alleviate other symptoms. However, it only makes things worse. Driving fast is an indicator of being revved up.

Q13. What should a member of the Reserve Component, who is no longer on active duty do if he/she experiences mental health difficulties that require medical expertise? What about their families?

A13. There are numerous opportunities for Reserve and National Guard Soldiers to receive immediate attention. They can contact Military One Source; Family Wellness or Family Support Program, Chaplains, unit command channel, medical channels, and the VA can also provide immediate attention or assist with access to care. The PDHRA provides a more formal review as well as access to care—this is available or active and separated Reservists.