The PTSD Toolkit for Nurses: Assessment, intervention, and referral of veterans

Abstract: Approximately 20% of veterans suffer from posttraumatic stress disorder (PTSD). NPs are well positioned to provide early detection and assist veterans with access to life-saving treatment. The PTSD Toolkit for Nurses helps nurses improve their skills in assessing PTSD and provides a specialized intervention and referral procedure that promotes help-seeking behavior among veterans.

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Mr. H presented to the primary care NP complaining of nightmares interrupting his sleep, irritability, a very short temper, and a sense of detachment from others. He deployed to Iraq in 2003 and then again from 2005 to 2006. He was exposed to numerous combat experiences, including witnessing a friend killed in action, surviving an injury from an improvised explosive device (IED), and experiencing mortar fire while under an attack in a remote base.

Mr. H sought help for his symptoms at the army base and was advised to follow up with a mental healthcare provider on his return to the United States. He deferred visiting the mental healthcare provider and managed well enough over the ensuing months. However, Mr. H continued to feel irritable and moody, which became a source of conflict between him and his wife.

In 2007, Mr. H deployed for a third time. When he began training exercises to prepare for deployment, his nightmares returned, and he was unable to shake off memories of his combat experience. He was also unable to sit through the training and lashed out at the commanding officer. Mr. H was having trouble getting to sleep and soon found he could not perform his job.

Military personnel

Mr. H's story is typical of a military person who develops posttraumatic stress disorder (PTSD) from traumatic experiences during military service. Nearly two-thirds (62%) of the 2.2 million troops that served in Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom in Iraq were exposed to serious training accidents, such as vehicle or

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helicopter crashes, coming under fire, or suffering from wounds caused by an IED, physical violence, or sexual assault.[1]

In 2011 alone, nearly 1 million service members or veterans received a diagnosis of at least one psychological condition while they were active service members, and half of them had two or more psychological conditions diagnosed.[2] PTSD is just one of many psychological consequences of war; other conditions include adjustment disorders, depression, anxiety disorders, and substance use disorders.

Signs and symptoms of PTSD or other psychological conditions are difficult to recognize, and veterans with these symptoms experience major barriers to reintegrating into society or the work force.[2] Veterans may be stoical and not easily share their symptoms. Unfortunately, delays in receiving help are common and raise the risk of negative consequences. With much stigma attached to mental illness, individuals with psychological problems tend to hide their conditions because they feel shame or guilt.[3] Therefore, nurses need to be alert to patients who have served in the military so as to properly assess their stress responses and need for help.

Consequences of untreated psychological conditions affect service members and their families alike, with the degree of hardship and negative consequences increasing with the number of the service member's exposure to traumatic or life-altering experiences.[3,4] One dire statistic—a veteran commits suicide every 65 minutes—suggests that veterans need assistance.[4,5] Psychological conditions resulting from experiences during military service or adjusting from military life to civilian life are treatable. Veterans and their families need to find help early.

Mr. H

Mr. H is a 25-year-old active duty marine infantryman who has been deployed twice to Afghanistan. While there, he experienced multiple traumatic incidents, including firefights and IEDs that detonated and killed a friend. Although Mr. H's friend was killed instantly, he feels responsible and guilty for not being able to save his life.

When Mr. H came back from his second deployment, he began to experience anger and irritability—especially with his wife and while driving in heavy traffic. He was emotionally distant and avoiding his wife; he spent extra time staying late at work. Mr. H was not sleeping well, so he drank a six-pack of beer every night hoping that it would help him fall asleep. He is easily startled and sometimes has very bad nightmares of his friend being killed. One day, when a friend slammed a freezer door shut, Mr. H had a flashback and relived the IED explosion. His marriage and job are in jeopardy.

Nurses have impact

RNs are the single largest group of healthcare professionals and work in all areas of healthcare.[6] All RNs, including NPs, meet active military service members and veterans in healthcare or community settings, such as churches, grocery stores, or social groups. RNs are in a unique position to make a difference in the lives of these men and women. First, the nurse must ask if the patient has served. In civilian dress, it is often not obvious that an individual served in the armed forces.

Once identified, the RN assesses for psychological symptoms of stress and trauma, determines the severity of the symptoms, intervenes, and refers the individual for help. RNs have the opportunity and position to help change the lives of service members and their families who experienced psychological trauma and continue to experience symptoms that disrupt their work or social lives. The PTDS Toolkit for Nurses is a self-directed online resource designed to teach or reinforce the nurse's knowledge about the treatment of veterans with PTSD.

The PTSD Toolkit for Nurses (www.nurseptsdtoolkit.org), sponsored by the American Nurses Foundation, was developed to teach nurses about the psychological consequences of stress and trauma (including PTSD) among veterans, to build competence in helping veterans take action to get help, and make referrals specifically for veterans. The PTSD Toolkit for Nurses is web-based and provides videos alongside brief case summaries that highlight essential points for nurses to assess, intervene, and refer veterans with PTSD.

Additionally, the website has interactive simulation for nurses to practice the assessment, intervention, and referral skills. This article reviews key points of the PTSD Toolkit for Nurses that promotes assessment of PTSD and interventions for veterans and family members to seek the help they need. NPs assess, diagnose, and treat complex health challenges, making them preferred providers for the often complex physical and emotional needs of veterans. NPs can use the PTSD Toolkit for Nurses to enhance their capacity for directed PTSD care.

Assessment

Symptoms of PTSD vary. Fear-based reexperiencing, emotional, and behavioral symptoms may be dominant for some individuals.[7] For others, a lack of pleasure in people or things that used to give them pleasure (anhedonia) or a persistent state of dissatisfaction, anxiety, restlessness, or fidgety mood may be most distressing.[8] For other individuals, reactivity and hypervigilance, including sensitivity to sounds, touch, and light, are prominent. In contrast, others have dissociative symptoms where they avoid or withdraw from people and places.[8]

Some individuals exhibit combinations of these symptom patterns. In the case study of Mr. H, his anger and irritability are dominant psychological symptoms (see *Mr. H*). He is also emotionally distant and detached, avoiding his wife and others. He uses alcohol to help him sleep. His arousal system is on hyper-alert, exhibited as being easily startled. Flashback symptoms are triggered by loud noises, and Mr. H often relives an experience in which he witnessed his friend being killed in an IED explosion. Even though Mr. H's psychological condition is painful, isolating, and threatening his marriage and job, he is embarrassed and reluctant to seek help.

Examples of traumatic events include shooting, mugging, burglary, physical or sexual assault, bullying, car crashes, serious injuries, and life-threatening illnesses.[9] Trauma can also be experienced by witnessing traumatic events. A close relative or friend can be indirectly traumatized when learning about a violent or accidental traumatic event. Such events include suicide, serious accidents, and serious personal injuries.

However, "death due to natural causes" does not qualify as a traumatic event for the purpose of diagnosing PTSD. The disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional (for example, torture, sexual violence, and intimate partner violence).[10] Individuals may experience extreme horror, fear, or a sense of helplessness when they witness or experience something so traumatic. They might exhibit a fight, flight, or freeze response.

Approximately 20% of military personnel and veterans develop PTSD, and those with physical injuries are 30% to 79% more likely to develop PTSD.[2] The risk of PTSD is higher among women; younger individuals; individuals with a lower enlisted rank; single individuals; individuals with a lower educational level; individuals with a history of childhood trauma or abuse; individuals who lack social support (such as friends or family); individuals who have been deployed more than once; individuals who have have more time exposed to combat; and/or individuals who are a member of the Army, Navy, Air Force, National Guard, or reserve.[11]

Symptom clusters of PTSD

PTSD has four main clusters of symptoms: reexperiencing, negative alterations in cognition and mood, avoidance, and hyperarousal.[10]

Reexperiencing. Certain contexts trigger intrusive memories of the traumatic event, nightmares, and flashbacks. Veterans may have a heightened psychological and physiologic response (such as fear or rapid heart rate) when exposed to these triggers.[10]

Mr. M

Mr. M is a 39-year-old Black male who served in the army from 2004 to 2006. During this period, he was deployed to Iraq. Since returning, Mr. M has had trouble reintegrating. His family life with his wife and four children is rocky, and he has been unable to get a job. Mr. M feels distant from his children and believes the children avoid him. He thinks the world is against him. Mr. M is currently being treated in the ED for minor injuries related to a bar brawl. He is drinking almost every night and is often in arguments or fights at the bar. Mr. M describes feeling at the end of his rope.

Negative alterations in cognition and mood. Alterations in cognition and mood can occur with exposure to trauma. Poor recall of the trauma and low self-esteem are characteristic of altered cognition and mood. For example, the individual may blame him- or herself or others for the traumatic event(s). Negative emotional states, such as fear, shame, guilt, and anger, may be disproportionate to the situation. Feelings of detachment or distance from others, including spouses, friends, and children, are characteristic of negative alterations in mood and cognition.[10]

Avoidance. Symptoms are characterized by thoughts or feelings of detachment from people, activities, and/or places. An individual with PTSD may avoid thinking or talking about troubling memories of the traumatic event. The veteran may exhibit anhedonia, which is a lack of interest in people, activities, or places that used to be pleasurable. A most troubling response is that the veteran may become emotionally detached from loved ones.[10]

Hyperarousal. Symptoms include distinct alterations in the arousal system of the brain.[8] The veteran may have problems falling or staying asleep and problems with concentration. He or she may be irritable or get angry with little or no provocation, which is typically expressed as verbal or physical aggression toward people or objects (see *Mr. M*). One may feel the need to constantly scan the environment and may have a heightened or exaggerated startle reflex (for example, responding to loud noises such as a car backfiring or during fireworks).

Mr. M's case exemplifies a hyperaroused response; however, his injuries are rooted in trauma incurred while serving as a soldier in Iraq. PTSD can easily be missed when a healthcare provider does not know that the patient is veteran. Providers should ask, "Have you served in the military?" Mr. M needs further evaluation for PTSD.

The symptoms of PTSD must be present for at least 4 weeks and the symptoms must cause a significant disruption

in the individual's ability to work or function in social environments.[10] For example, sleep disturbances may cause an individual to oversleep and be late for work, resulting in poor work performance, irritability, or angry outbursts. Often, PTSD coexists with other mental health or medical disorders, such as depression, anxiety, traumatic brain injury, or substance abuse. In addition, individuals are at increased risk for suicide.[12]

Anxiety or fear is a normal physical and psychological response to stress. Individuals vary in coping with and adapting to experiences that cause anxiety or fear. However, an emotional reaction to stress or trauma is not a criterion for a PTSD diagnosis.[13] Prominent symptoms of anhedonia, dysphoria, angry and aggressive symptoms, or dissociative symptoms following exposure to stressful and traumatic psychological conditions are distinctly associated with the PTSD diagnosis.[13]

Ms. S

Ms. S is a single, 20-year-old Mexican American U.S. Navy veteran. She served for 2 years, during which she was deployed to Equatorial Guinea to work as a translator. Ms. S was released with an honorable discharge 6 months ago related to PTSD symptoms following a traumatic experience while serving. She was admitted to an inpatient psychiatric unit after a suicide attempt. Ms. S is currently on suicide precautions. She describes feeling detached and distant from her family. Ms. S's family has always been her greatest sense of connection and support. She has not found work since leaving the military and she feels guilty that she is not trying hard enough. Ms. S expresses inordinate shame about her current situation, which grew exponentially when she was admitted for a psychiatric hospitalization.

Ms. L

Ms. L began her military service at age 21. She has been a service member for the past 14 years. Ms. L was deployed three times to the Middle East. Her most recent deployment was to Afghanistan, where she witnessed frequent combat-related injuries and violence such as amputations, disfigurements, and bombings. Ms. L returned home where she is currently raising two sons with her husband of 16 years. For more than a month, she describes feeling irritable and distant from her sons and husband; she knows that they notice her distance and she is concerned that her husband is unhappy with her remoteness. When Ms. L sleeps, she wakes frequently from nightmares about a friend who died in an explosion. She feels jumpy around loud noises. Ms. L's greatest concern is keeping her family together, as she feels she is losing them.

Such experiences of psychological distress following exposure to catastrophic or aversive events is grouped as a trauma and stress-related disorder by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5).[14] An individual may have some combination of PTSD with or without anxiety, depression, substance use, or other physical problems (see *Ms. S*).[15]

Psychological distress following exposure to a traumatic or stressful event can vary widely depending on the individual's psychological coping reserve and the context of the experience. Ms. L's history shows she was in the military for many years without developing PTSD (see *Ms. L*). During her most recent deployment, she witnessed an IED explosion that left a friend with multiple limb amputations. Irritability, emotional detachment from her husband and sons, sleeplessness, and flashbacks prevent her from working.

Ms. L is most concerned that her marriage is dissolving and she is not able to care for her children. Ms. L came to the attention of the nurse who was caring for her while she was in the hospital for a minor surgical procedure. Ms. L complained about not sleeping and asked for a sleeping medication. The nurse asked her if she had served in the military. Inquiring about a military history opened the door for Ms. L to share her ongoing psychological symptoms and her worry about losing her family.

Ms. L, Mr. M, Mr. H, and Ms. S represent veterans who had problems transitioning back to civilian life. Ms. L was an outpatient, Mr. M was seen in the ED, and Ms. S was a patient in the hospital. The fact that they are veterans is not readily apparent, making it essential that nurses ask the question "Did you serve in the military?" If the response is yes, the nurse must evaluate the patients' conditions carefully and refer them for treatment with a mental healthcare professional who understands the military context of PTSD. The American Nurses Association initiated a national campaign titled "Have You Ever Served in the Military?"(www.haveyoueverserved.com) to raise awareness of all nurses to identify veterans.[16]

Assessment of symptoms is the first step in an integrated treatment approach between the healthcare providers, the patient, the family, and behavioral healthcare. There are several recommended questionnaires that can assist in screening for a PTSD condition. For example, the PTSD checklist has a military, civilian, and specific trauma version.[17] The PTSD Checklist-Military (PCL-M) has 17 questions with responses on a Likert scale.[17]

Examples of the questions include: Over the last month, how much you have been bothered by repeated, disturbing memories, thoughts, or images of a stressful military experience?

Stages of Change: Intervention Matching Guide

1. Precontemplation

- Offer **factual** information
- Explore the **meaning of events** that brought the person to treatment
- Explore **results of previous efforts**
- Explore **pros and cons** of targeted behaviors

2. Contemplation

- Explore the person's **sense of self-efficacy**
- Explore **expectations** regarding what the change will entail
- **Summarize** self-motivational statements
- Continue exploration of **pros and cons**

3. Determination

- Offer a **menu of options** for change
- Help identify **pros and cons** of various change options
- Identify and **lower barriers** to change
- Help person **enlist social support**
- Encourage person to **publicly announce plans** to change

4. Action

- Support a **realistic view** of change through **small steps**
- Help **identify high-risk situations** and develope **coping strategies**
- Assist in **finding new reinforcers** of positive change
- Help access family and social **support**

5. Maintenance

- Help identify and try **alternative behaviors** (drug-free sources of pleasure)
- Maintain **supportive contact**
- Help **develop an escape plan**
- Work to **set new short- and long-term goals**

6. Recurrence

- Frame recurrence as a **learning opportunity**
- Explore possible behavioral, psychological, and social **antecedents**
- Help to develop **alternative** coping strategies
- Explain the Stages of Change and encourage person to **stay in the process**
- Maintain **supportive** contact

Adapted from Prochaska JO. Transtheoretical model of behavior change. *Encyclopedia of Behavioral Medicine.* Springer; 2013:1997-2000. Used with permission.

In addition, over the last month, how much have you been bothered by suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?[17] The PCL-M is available online at http://sph.umd.edu/sites/default/files/files/PTSDchecklist.pdf. NPs can incorporate this questionnaire to screen for a PTSD condition. A 20-item self-report measure, the PTSD Checklist for DSM-5 (PCL-5) is used to screen individuals for PTSD and monitor symptoms during and after treatment.[18] The PCL-5 can be used to provide a provisional PTSD diagnosis. A complete diagnostic assessment and treatment by a mental healthcare professional with experience with military PTSD is recommended.

Intervention

Ideally, mental healthcare professionals who have specialty education and experience with the veteran population should do the diagnosis and treatment of veterans with PTSD. However, access to mental healthcare professionals may take time, and much work can be done to prepare a patient for treatment. NPs can evaluate patients' readiness for seeking help and help patients take steps to understanding their condition and prepare them to accept professional help.

One of the most important parts of the initial assessment includes evaluating the extent to which the military member or veteran is ready to seek help. In today's military, many

factors, such as stigma or embarrassment, keep service members from seeking out help—especially when it involves a behavioral or mental health problem. It is also an important cause of dropping out of care prematurely.

Although there has been an aggressive anti-stigma campaign waged both in the military and in civilian populations, stigma remains a strong barrier to help-seeking. Being mindful of stigma and its impact on care-seeking behaviors is a critical component for assessing patients with PTSD.[8,19,20] Perhaps the greatest contribution by NPs and all healthcare providers is to evaluate patients' perceptions of barriers to accepting mental healthcare and then guiding them to seek help.

Prochaska's concept of readiness for change is a helpful conceptual framework (see *Stages of Change: Intervention Matching Guide*).[21,22] The change model establishes whether or not the patient believes that he or she has a problem; if the patient has intent or willingness to seek assistance for the problem; if he or she is currently engaging in activities that help to solve the problem; if he or she is maintaining behaviors that have been successful in helping the problem; or if the patient has relapsed into old negative behaviors and is willing to restart treatment again.[21]

Strengthen motivation to get help

After the NP identifies where the patient is in the change continuum, the NP elicits and strengthens a patient's motivation for seeking help (see *Changes: Perceived need for help*).[21] To be effective, the NP must understand the patient's perception and motivation for seeking help that is congruent with his or her own values, beliefs, and wishes.

The nurse's response is grounded in a respectful stance with a focus on building rapport in the initial stages of a relationship. Too often healthcare providers talk *at* the patient about what he or she should and should not do, or healthcare providers focus on how to "fix it." These approaches may aggravate a patient's guilt and shame about his or her symptoms and alienate the patient.

There are three essential elements to the PTSD nurse-patient intervention:[23]

- Build a partnership with the individual that is grounded in the point of view and experiences of the patient. The patient is the expert on his or her traumatic past and current symptoms. An effective partnership is one that builds mutual understanding, not the NP being right or having the right answer to problems.
- Draw out the patient's story by seeking his or her thoughts and ideas without making an attempt to fix the problem or imposing personal opinions. Motivation and commitment to change are most powerful and sustainable when they come from the patient.
- Ultimately, it is up to the patient to follow through with making a change. This is empowering to the individual but also gives the patient responsibility for his or her actions. The NP reinforces that there is no single "right way" but, in fact, there are multiple ways that change can occur.

Motivational interviewing principles and techniques are excellent guides for the NP.[24] There are four distinct principles, and it is helpful to hold true to these principles throughout the patient's treatment.

- *First, express empathy.* Empathy involves seeing the world through the military members' eyes, thinking about things as they think about them, feeling things as they feel them, and sharing in their experiences. This approach provides the basis for military members to be heard and understood; in turn, they are more likely to honestly share their experiences in depth. It is critical to listen without judging during this process.
- *Support self-efficacy.* The PTSD intervention is a strength-based approach that assumes the individuals have within them the capabilities to change successfully. An individual's belief that change is possible is needed to instill hope about making those difficult changes. Focus on the patient's previous successes and highlight skills and strengths that the patient already has.

Changes: Perceived need for help

	Not ready	Unsure	Ready	Change
Behavior change	"There is no problem."	"There may be a problem, but I have mixed feelings."	"There is a problem and I want to change."	"My change(s) are working for me now."

Adapted from Miller WR, Rose GS. Motivational interviewing and decisional balance: contrasting responses to client ambivalence. *Behav Cogn Psychother.* 2013;11:1-13. Used with permission.

- *Roll with resistance.* Resistance may occur when a patient experiences a conflict during treatment. Rather than being confrontational, the best approach is to deescalate the situation, examine the concerns of the patient, and guide the patient in identifying his or her own solutions to the problem. This will help reduce resistance and reinforce motivation for treatment.
- *Help the patient identify where he or she is now and where he or she wants to be.* This will help define patient-identified treatment goals and encourage motivation for change.

On the PTSD Toolkit for Nurses website (www.nurseptsdtoolkit.org), there are additional PTSD intervention strategies adopted from motivational interviewing techniques.[25,26] These strategies will help NPs develop a therapeutic relationship with the patient throughout the assessment, intervention, and referral phases.

Referral

After determining a positive screen and discussion of the results with the patient, NPs should identify community referral resources, including both private clinicians and Department of Veterans Affairs (DVA) resources, which specialize in evidence-based care for veterans with PTSD. NPs should also maintain a list of current available resources so the veteran can participate in selecting the preferred referral. According to the Institute of Medicine, the DVA offers a full range of PTSD treatment, including services to prevent, screen, and diagnose PTSD.[27]

Referral for treatment may include veterans receiving care through DVA primary care clinics (which include primary care mental health integration teams) or patient-aligned care teams (which provide an effective approach for managing those with low-to-moderate symptoms of PTSD). Many other DVA-specialized outpatient and inpatient treatment programs exist to help those veterans with more severe symptoms.

Active military members are provided with free mental healthcare through their local military medical care system or through a referral via the military medical system called TRICARE (www.tricare.mil). DVA provides mental healthcare for eligible nonactive military members and veterans. A veterans affairs eligibility checker and PTSD program locator (www.va.gov/directory/guide/ptsd_flsh.asp) can further assist healthcare providers in the referral process.

DVA also has a variety of electronic resources for both professionals and veterans, including a Community Provider Toolkit (www.mentalhealth.va.gov/communityproviders/index.asp#sthash.SE96f1ID.dpbs) to provide information regarding military culture as well as screening tools. A public DVA website (www.mentalhealth.va.gov) describes a variety of mental health services and resources for healthcare staff and veterans. Resources specific to PTSD include continuing education for staff (www.ptsd.va.gov/professional/continuing_ed/index.asp) as well as a PTSD online coach and mobile application for veterans (www.ptsd.va.gov/public/treatment/cope/index.asp).

Military service members and veterans are also afforded eight free sessions of mental healthcare through the Military One Source referral program (www.militaryonesource.mil). By calling the number on the website, the program will connect the military member or veteran with a local mental healthcare provider. For those with comorbid substance abuse problems, pain, and sleep disturbances, it is important to get them involved with multidisciplinary collaborative care early to ensure maximal success.

When referring care to another healthcare provider, it is best to do a "warm handoff" by verbally contacting the accepting provider with the patient and assessment information.

Moving forward

The assessment, intervention, and referral information in this article provides NPs with the basic tools to get veterans and their families with PTSD the help they need. Even if a veteran does not progress to PTSD, he or she can have adjustment problems when transitioning to civilian life. Using the assessment, intervention, and referral steps presented in this article, NPs can help these individuals.

NPs help individuals adjust to life stressors. NPs need to identify veterans to determine risk for PTSD or other psychological conditions associated with military life and the transition to civilian life. NPs can make a difference in whether or not military members and their families transition successfully to civilian life. NP

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