Trauma-Informed Care for Primary Care: The Lessons of War

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More than 2 million Americans have deployed to the wars in Iraq and Afghanistan over the past decade. For these individuals, anticipated and actual exposure to life-threatening events were a routine part of daily life. Similarly, natural disasters, such as Hurricane Katrina, the recent natural and man-made consequences of the Japan earthquake and tsunami, the massive Southeast Asia tsunami of 2005, and tornadoes tearing through the Southeast United States, have placed in graphic relief the traumatic events that affect many millions of lives every year. Even in our everyday life (and medical practice), trauma is ever-present: sexual assault, domestic violence, gang shootings, and accidents. In the United States, over 10 million motor vehicle accidents result in more than 35,000 deaths each year (1). If we told our hospitals that 34% of everyone in the intensive care unit had a staphylococcal infection, they would immediately institute screening, treatment, and observation. Yet we know that approximately that rate of the intensive care unit had a staphylococcal infection, they would immediately institute screening, treatment, and observation. Yet we know that approximately that rate of posttraumatic stress disorder (PTSD) occurs in patients presenting to hospital trauma units after serious motor vehicle accidents. Regardless, assessment for PTSD and other trauma-related disorders is not a standard of care in emergency departments, nor in outpatient settings where many patients affected by trauma present.

Posttraumatic stress disorder manifests as intrusive thoughts and memories of traumatic events; attempts to avoid reminders of the event; and startle, arousal, and sleep problems. We often talk of PTSD as being associated with memory problems; however, it can also be considered a disorder of impaired capacity to “forget.” The adaptive aspects of forgetting are seldom recognized, perhaps in part because of psychoanalytic perspectives that focus on the importance of remembering (and do not recognize that the goal of remembering is often to be able to forget) and because of our attention to the aging population and dementia, such as Alzheimer disease. But forgetting is probably a much more important function for our brains than remembering. We are constantly taking in information and if we could not “forget,” our brains would rapidly go on overload. So is PTSD a disorder of impaired forgetting?

Posttraumatic stress disorder is certainly a “brain injury” in that an environmental event (although not necessarily a blow or bullet) has altered the brain. We know this from imaging studies that show changes in the hippocampus, amygdala, and prefrontal cortex—the primary regions associated with PTSD (2). Posttraumatic stress disorder is not the only mental disorder associated with traumatic events: depression, panic attacks, and substance abuse are also common. Depression and substance abuse are common comorbid conditions of PTSD. There are abundant data that everyone is at risk for PTSD, given a sufficiently traumatic event. Many if not most people have nightmares, avoidance, numbing, negative thoughts, and arousal after common trauma. Most also recover over a few months. Thus, PTSD, similar to other diseases in medicine, can be like a common cold that resolves without treatment or can progress to pneumonia with severe morbidity (2). Too often we and the public speak of all psychiatric illnesses as if they were cancer. But psychiatric illness, like most medical illnesses, may be in the form of a bruise or a broken bone—not always cancer.

In addition to PTSD, recent attention has focused on the increased rates of suicide in the U.S. Army during the conflicts in Iraq and Afghanistan (3). In World War II, rates of suicide were lower than in peacetime. But now, rates of suicide in the U.S. Army have nearly doubled over the past decade. Before the wars in Iraq and Afghanistan, rates of suicide in soldiers were about half that of age- and sex-matched general populations; that is, being in the Army predicted a lower risk for suicide. Now the rates are about the same as age- and sex-matched populations (about 20 to 22 per 100,000 per year) (4). Although it is tempting to focus solely on the suicide rate of combat veterans, suicide remains a leading cause of death among youth and working-age U.S. men. In the general population, suicide is nearly as common as vehicular death. Suicidal ideation is predicted by depression, so detecting depression is an important step in preventing suicide whether the patient is a combat veteran with war-related PTSD or a civilian who has less visible trauma. Specifically inquiring about suicidal risk is critical.

There are brief assessment tools for PTSD and depression that are useful in primary care settings (5). Obtaining mental health care is often challenging and dependent on health insurance options and state or county programs. Recent changes to Medicare support reimbursement for depression screening (6). Two questions during patient assessment in a variety of settings can help to determine the need to assess for PTSD or suicidality: “Have you ever been in a setting where your life was in danger?” and “Have you had any thoughts of wanting to hurt yourself (or someone else)?” The first question, which asks about life-threat exposure, is equivalent to an exposure to a “toxin” and an affirmative answer should lead to further assessment. Similarly, thoughts of wishing to hurt oneself are of serious concern. Depression, even without suicidality, has significant effects on health and alters family function and parental caregiving. Suicidal thoughts or plans warrant further evaluation and assessment.
The challenges experienced by military members returning from combat deployment remind us of the toll that exposure to traumatic events may exact on well-being. Concern for the welfare of those returning from war has historically led to better characterization of, and development of treatments for, trauma-related distress and dysfunction as well as for physical injury, infectious diseases, and toxin exposures. War has taught us much about these processes. But traumatic exposure and trauma-related distress and illness are not military-specific phenomena. Accidents, violence, and natural and man-made disasters occur in times of peace and war. A new focus on national health care provides an opportunity to address national health issues. Trauma-informed care—recognizing and planning for detecting and treating the disorders that result after traumatic events—will benefit not only military personnel, but all patients. Posttraumatic stress disorder and depression are perhaps the most common disorders related to traumatic events (7). We have good treatments for both and should identify patients in need of these interventions.

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