

The man dancing with the death

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A Case of a Soldier Suffering from PTSD, Who Was Treated by Means of the Controlled Stress Exposition Method Using Virtual Reality and Behavioural Training



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Anamnesis

- A 30-year old Private, serving in the armed forces for 5 years as a career soldier.
- He was the eldest out of seven brothers and sisters.
- Grown up without parental supervision.
- Father without a permanent job, taking casual jobs, abusing alcohol, combative, using physical violence against his family members.
- Mother working abroad for years in order to improve the difficult economic situation of the household.
- He finished both the primary and vocational school on time, without repeating any grade, combative, aggressive and auto-aggressive.



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Anamnesis

- In 2000 he was called up into the army to serve as a conscript
- He decided to join the army as a career soldier.
- His superiors appraised him as a soldier who fulfils his duties well
- In January 2007 he was deployed to Iraq within the rotation 8th of the Polish Military Contingent.
- Alike to his service in Poland, at the deployment he was a gunner



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First Traumatic Event

- On March 9, 2007, during changing of the guards, he was unintentionally shot by his colleague.
- He was standing in the front when the colleague, having changed the magazine, inadvertently reloaded the weapon and fired a ripple of 3 rounds.
- The projectile penetrated the victim's helmet, slid along its internal shell curvature and left the shell causing only a scratch on the scalp skin.



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First Traumatic Event

- After the shot he fell on the ground, but he did not lose conscience.
- He claimed nothing wrong had happened to him, he demanded somebody to take a picture of him.
- In the night, despite no brain damage symptoms he could not sleep and vomited several times.
- In ten days after that accident he returned to his duties. However, from that time he began to respond differently to the sound of weapon reloading and he was more watchful in weapon handling.
- The accident triggered also a nervous motoric twitch. His thoughts were often returning to the accident. Sleep disorders and lack of appetite were occurred.



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Second traumatic event

- One month later, when he was a guard of honour he was “shot” at the rear part of his head by a cap of a cream tube.
- Contents of the tube hit the patient precisely in the same place as the bullet a month before.
- He grasped his head in this place and had an impression that the cold sticky cream he touched with his hand was his blood. He even saw the blood colour on his hand.
- Then he knelt down trembling all over and in a moment he began to cry. He does not remember himself crying, even when he was a child.



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Third traumatic event

- Some two weeks after this incident one of Polish soldiers was killed. During the funeral celebrations he had visions of his own death.
- He felt the Death had made a mistake, it was waiting for him and it would rectify its previous mistakes.
- In the evening of the same day a rocket attack was launched on the Divaniyah base. Just before the attack the patient was going to the laundry but he turned back because he had forgotten some of his things he wanted to wash. In that time a large-calibre projectile hit the laundry building, destroying it completely and killing an American civil employee.



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Third traumatic event

- In the night after this incident the patient vomited.
- He had a feeling he had evaded Death again but it persistently tracks and follows him.
- Next day he packed his things to prevent somebody else having to do that when he die.
- He called his brother in Poland with whom he was in conflict for a long time to apologise him for all bad things and say farewell.
- From that time symptoms of post-trauma stress were developing very fast.
- After a psychological and psychiatric consultation it was decided to send him back to Poland.



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First hospitalisation

- Immediately after his return to Poland he was admitted to the Department of Psychiatry and Combat Stress and stayed there from April 29, 2007 to August 10, 2007.
- No symptoms of depression or psychosis were found.
- He was complaining about chronic headaches, insomnia, nightmares associated with traumatic events from Iraq and visions of his own death.
- He had visible twitches in the area of his jaw, head and right shoulder and he was stuttering.



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First hospitalisation

- Citalopram, Carbamazepine, Haloperidol and Risperidon were used in the therapy.
- He tolerated the pharmacotherapy well and without objections however, his attitude to any forms of psychological help was sceptical.
- Each time when a medical helicopter was landing at the hospital's helipad, the patient was responding with hunching, staring for a threat behind the windows and sometimes even with a desire to hide under the hospital bed.
- Up to the end of the hospitalisation he was not able to sit during everyday therapeutic sessions with his back turned to the windows.



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First hospitalisation

- He was also seeking isolation and trying to hide from sight of other people.
- He often experienced nightmares, described by him as “strange dreams”. He was writing poems showing his fascination with the mystery of Death.
- With time he became much calmer. The decline of both tension and arousal was also reflected in rarer use of vulgarisms as well as minimisation of twitches.
- This time he did not decide to participate in the exposure therapy using virtual reality.



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First hospitalisation

- After the first attempt he responded to the sound generated by the equipment with anxiety, tension, vegetative arousal and left the VR therapy room.
- However, he agreed to work on incoming intrusion thoughts (the first stage of therapy before an exposure to VR).
- He was discharged from the hospital with a diagnose of PTSD in a balanced mental condition and with a recommendation for continuation of the therapy as an outpatient.
- Also a medication with Citalopram - 60 mg/die, Risperidon - 1 mg/die and Carbamazepine - 600 mg/die was recommended.



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- It was assessed that, despite an improvement, the patient was not able for return to military service and needed to be examined by the Military Medical Commission.
- He was also responding with fear to the prospect of returning to military service.
- Less than 4 month later, during a control visit to the Mental Health Clinic the patient was qualified again for hospitalisation due to recurrence of PTSD symptoms.
- During a conversation that preceded the qualification for a hospitalisation, attention of the psychiatric consultant was attracted by an increase in twitches that had been nearly completely eliminated within the previous hospitalisation.



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- Other attention-attracting factors were apathy of the patient, his amimic face and his distancing from all forms of social and every-day activities that seemed to be a mask for many suppressed negative emotions.
- These negative emotions were confirmed just by coincidence. When the patient was rising from a chair, a 35 – 40-cm long bayonet fell out from an internal pocket of his jacket.
- Then he admitted that being in the street, among other people he felt uncertainty and fear. Concerns about his own life and visions of his death emerged again.



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Second hospitalisation

- The patient was re-hospitalised from November 26, 2007 to April 29, 2008.
- Upon his admission to the Clinic the medication was changed to Sertraline - 200 mg/die, Haloperidol - 2 mg/die and Valproinic acid - 600 mg/die.
- He participated in everyday sessions of group therapy and weekly individual sessions.
- The first anniversary of the day when he was shot, when he “escaped Death”, fell during this second hospitalisation.
- This date was literally magical to him. He felt that something horrible would happen to him on this very day.



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Second hospitalisation

- After this event the patient's mental condition became balanced. The team of a psychologist and psychiatrist began to notice that this condition was unnaturally static.
- Due to multi-month hospitalisation and psychotherapeutic actions has become a kind of a veteran of the ward and the psychotherapy programme.
- Although he was actively participating in all therapeutical activities, they were not resulting in further improvement of his condition.



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Second hospitalisation

- Thus a new plan of psychotherapeutic treatment was developed.
- He was to undergo a cycle of Virtual Reality (VR) sessions taking place twice a week and next the patient was to be exposed *in vivo* to effects consisting in a direct participation in shooting training.
- In order to prevent a withdrawal of the patient, this plan was presented to him as obligatory for qualification for discharge from the hospital.



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Exposure Therapy Using Virtual Reality (VR)

- Altogether 22 VR sessions were provided.
- Prior to the VR therapy three sessions were provided to refresh the attention concentration training
- VR stimulation was used from session 4.
- The patient also saw the whole session data records on the screen that provided him with feedback on his own capabilities of effecting the measured results by, e.g. breathing control.
- Rebuilding his belief he is able to control his symptoms, he was gaining a stronger belief he was not so submissive in his “dance with Death”.
- The patient was able to see in his imagination further sequences of pictures that were not displayed on the computer screen and were not included in the graphic software.



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Exposure *in vivo*

Exposure *in vivo* was planned as a three sessions of participation of the patient in shooting training with live ammunition.



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Exposure *in vivo* first session

- The patient was supposed to be an observer of the shooting
- The goal was to evaluate his response to the sight of the real weapon.
- He was experiencing a big anxiety, he responded to the first shots with a strong, fear-related twitch of his whole body.
- Having returned to the clinic the patient went to bed and slept nearly all afternoon.
- In the evening he was complaining about pain of his legs muscles, buttocks and back similar to those experienced after an extensive physical effort.



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Exposure *in vivo* second session

- The patient was supposed to participate passively in all activities within shooting training but without firing on his own.
- He was told to take a position on the firing line and, correspondingly to orders of the instructor, reload his weapon and „fire” it without ammunition.
- On the positions on his left and right side other soldiers were firing using live ammunition.
- At that time the patient experienced the same feelings like during the first exercise; however, he figured out himself that these symptoms abated already during the exercise and the afternoon sleepiness was smaller alike the muscle pain.



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Exposure *in vivo* third and fourth session

- He was to participate fully in the firing.
- With full mobilisation and full control of his own fear, he did the firing but none of his 20 shots hit the target.
- However, he was glad about his achievement.
- After this session he asked about participation in one more exercise like that.
- Trip to the shooting range turned out to be a complete success. The patient, without any fear fired 20 shots hitting all the targets.
- After that session, on his way back to the clinic, he stated himself he did not know how this happened, but he was no longer afraid of weapon and wanted to continue his military service.



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Effects of Treatment and Psychotherapy



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Psychological diagnosis

- A psychological diagnosis was performed during both hospitalisations.
 - Both psycho-organic tests and neuroimaging examination ruled out any organic changes on the central nervous system structure.
 - MMPI-2
 - Questionnaires for measurement of the PTSD
 - Mississippi Scale
 - Watson's PTSD Interview
 - Combat Exposure Scale (CES),
 - Impact of Event Scale (IES)
 - STAI
 - CISS
- The result show how the patient's general adjustment level was growing over time: after nine months of intensive therapy and twelve months of medication a drop in PTSD intensity was found, from extreme to very significant or significant.



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Outpatient Check in Third Month after Check Out

- He was in a balanced mental condition.
- He was reporting major changes to occur within several months in his personal life.
- He declared he felt very well and was able even to participate in firing ground exercises including firing
- Control VR session confirmed permanence of the patient's mental health improvement.



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Summary

- Young soldier who a year ago used to avoid all activities, decided to return to the professional military service.
- At present the patient deals with weapon within his everyday duties despite the fact that just a dozen or so weeks ago it was horrifying him.
- He began to plan his future personal life while a year ago he claimed nobody could be trusted and he himself is empty and burnt out.



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Conclusions

- The presented case study of treatment of a full-symptom PTSD syndrome of significant intensity in an Iraqi mission veteran has shown effectiveness of the therapy using VR.
- The method of combining the VR and in-vivo in PTSD therapy seems especially efficient in cases resistant to other forms of psychotherapy and medication.



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Thanks for your attention



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PSYCHOLOGICAL SUPPORT FOR THE ROMANIAN COMBAT TROOPS BEFORE, DURING AND AFTER DEPLOYMENT

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*Lt.(r) MARIA-MAGDALENA MACARENCO, Specialist in Military and Clinical
Psychology, 348th Battalion Constanta*

COMPONENTS OF THE PROGRAM:

- **I. PSYCHOLOGICAL SELECTION.**
- **II. PSYCHOLOGICAL TRAINING FOR THE MISSION.**
- **III. PERMANENT PSYCHOLOGICAL SUPPORT DURING THE MISSION**
- **IV. PSYCHOLOGICAL POST -DEPLOYMENT EVALUATION**

I. PSYCHOLOGICAL SELECTION of the troops before the mission training program

- We evaluate soldier's personality, intellect and motivation ;
- if one of those criteria comes up negative, the soldier will be rejected from the mission training.



II. PSYCHOLOGICAL TRAINING FOR THE MISSION

Three month prior to deployment , Romanian troops receive information which accurately describes the missions, theater of operation and specific battlefield risks. During this time, soldiers are put through gradual training exercices so they will be able to perform and function in both normal and battle conditions.



We teach soldiers about:

- Possible disturbances in behaviour during a battle and its consequences;
- psychosomatic changes due to the environment factors ;
- stress management techniques and different methods of controlled breathing;
- emotional reactions and psychological disorders of soldiers during previous missions;
- psychological implications of temporary family brake-up.



During the entire period of training, the psychologist is among the soldiers almost every day, observing and getting to know them better. At the end of the training program, the soldiers who do not achieve the military, physical and psychological performance standards are not allowed to proceed with the mission.

III. PERMANENT PSYCHOLOGICAL SUPPORT DURING THE MISSION

The most important part of the program is that the psychologist lives inside the deployment camp, where he/she can immediately evaluate and assist a soldier who has signs of combat distress and to stop symptoms for becoming chronic. On the other hand the psychologist could have a better control over the soldier's evolution.



After incidents resulting in dead, wounded or captured soldiers, the psychologist will apply the following intervention measures:

1. a) the first step is **crisis intervention** which is mandatory for decreasing the emotional tension of the subject. It will take place the moment he returns to camp. The session will last until the subject is emotional stabilized, no matter how long it takes. We do not prescribe medication.

- 
1. b) the psychologist will establish a therapeutical plan for the subject, depending on his psycho-emotional evolution, untill he recovers and is capable of returning to missions.
 1. c) the soldier will recieve psychological support whenever necessary.
 1. d) if the soldier cannot be emotional recovered in a short time, he will be repatriated so he avoids contaminating others.
 2. counseling the soldier's friends to provide him emotional support whenever necessary.

IV. PSYCHOLOGICAL POST-DEPLOYMENT RECOVERY

Consist in 4 steps:

- a. Psychological training for readapting to family, social and professional life;
- b. Psychological evaluation;
- c. Psychological intervention;
- d. Psychological evaluation of family, professional and social group post-insertion.

IV. a) Psychological training for readapting to family, social and professional life

- It's done by the psychologist from the theatre, 10 days before the troops are to return home.
- In the same time, the psychologist of family support group is doing a similar training in the country, with the soldiers families about what are the possible reactions expected from them.

IV. b) Psychological evaluation

- It starts the first two days from repatriation and consist of a semi-structural interview in order to detect psychological disorders caused by the mission.

IV. c) Psychological intervention

- One to three weeks from repatriation, the soldiers diagnosed with different disorders are included in a psychotherapy plan by the unit psychologist;

IV. d) Psychological evaluation of family, professional and social group post-insertion

- Two month from returning to work, the unit psychologist evaluates the readjustment and reinvestment in personal and professional life, by taking a semi-structural interview both with the soldier and his family. Depending on the severity of the problem, the subject is included in a psychotherapy plan.

CONCLUSIONS

Our small percent of militaries with emotional distress is based on the following issues:

- Good selection before the mission;
- Early intervention following a traumatic event. No medication;
- Permanent psychological support of the soldiers, no matter if the problem is caused by the battle stress or not;
- Early psychological evaluation and intervention after deployment.

Thank you!





Virtual Reality & Biofeedback to Help Warfighters deal with Stress

**MAJ Melba del Carmen Stetz, Ph.D.
Tripler Army Medical Center, Hawaii**

October 18-21, 2009

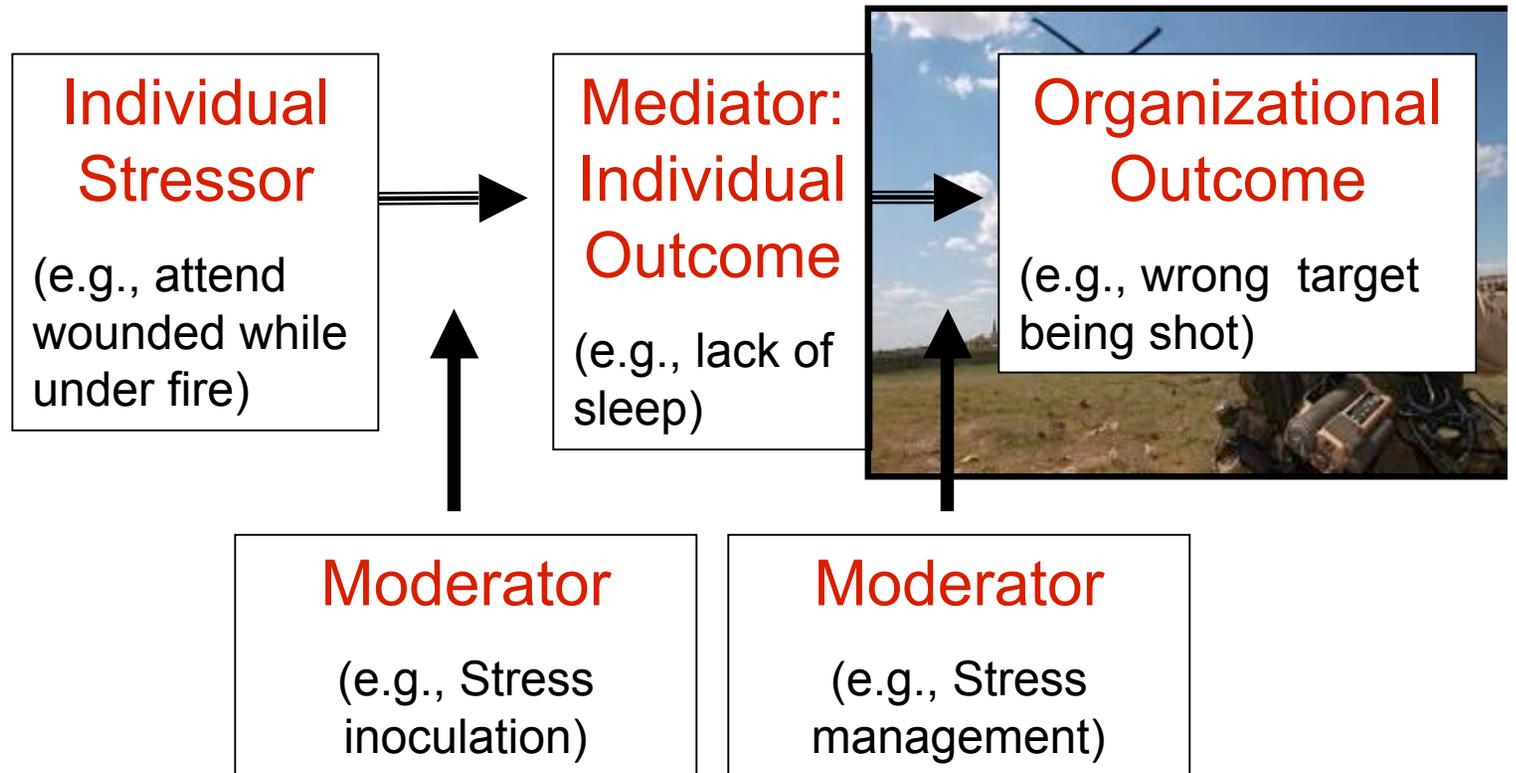
NATO Advanced Research Workshop:

**Wounds of War II: Addressing Posttraumatic Stress Disorder in Peacekeeping and
Combat Troops**

Südkärnten, Austria

The views expressed in this abstract/manuscript are those of the author(s) and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. Government.

Combat Stress-Outcome Relationship





Facts

- Many warfighters are coming back from the theater with combat stress symptoms and traumatic

1. Hoge, R.E., et al. (2002). Combat duty in Iraq and Afghanistan...New Eng J Med...
2. Hoge, R.E., et al., (2005). Psychiatric Diagnoses as a Cause of Medical Evacuation. Av, Space, and Environmental Medicine, 76 (7), C15-20.
 - n = 5, 671; OEF/OIF MedEvac records
 - **Psychiatric problems were 1/5 top reasons for the MedEvac**
3. Stetz, M.C., Castro, C. A., & Bliese, P.D. (2007). The Impact of Deactivation Uncertainty, Workload, and Organizational Constraints on Reservists' Psychological Well-being and Turnover Intentions. Military Medicine, 172, 576-580.
 - **n = 263 activated MPs after 9/11**
 - **↑ uncertainty, workload, & org. constraints = ↓ psychol well-being & ↑ turnover intentions**



Some Warfighters' Stressors

- Dangerous work environment
- Poor self-efficacy
- Poor leadership
 - Lack of a system
 - Sleep deprivation
- Poor support system
 - Friends, family



Stress Considerations

- Model
 - Symptoms
 - Occurrence
 - Duration
- Culture
 - Individual (deployment history) (see Killgore, Stetz, Castro, & Hoge, (2006). *Somatic and Emotional Stress Symptom Expression Prior to Deployment by Soldiers with and without Combat Experience*. J Psychosomatic Res. 60. 379-385).

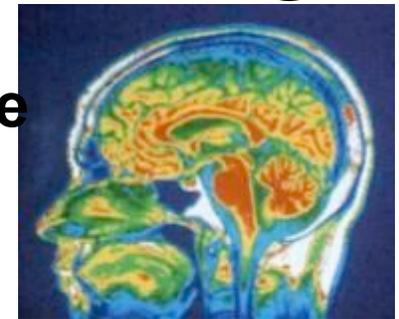


Stress Management Options

- **Psychopharmacology**



- Selective Serotonin Reuptake Inhibitors; Antidepressants
 - Dependence, interference



- **Psychotherapy**

- Critical incident stress debriefing
- Cognitive-Behavioral
 - Exposure
 - In-vivo





Stress Inoculation Training

- *“A flexible individually-tailored multifaceted form of CBT.”*

(Meichenbaum, 1996).

- **Applied to military:** (Rothbaum et al., 2001; Rizzo et al., 2006; Wiederhold & Wiederhold, 2008; Stetz, Long, Wiederhold, Turner, 2008).

- **3 Steps:**

Education, Practice, and Application⁷



Facts:

Gaming & Warfighters

- (+) Many warfighters are computer/ game-oriented**
(e.g., FM 7.0: Training for Full Spectrum Operations.)
- (-) Most video games are based on stressful scenarios.**



Why Virtual Reality-SIT?

- Playing videos vs. going to the shrink
- Immersion via gaming vs. facing a shrink, imagining (Stetz, Bouchard, Wiederhold, & Folen, 2009. *The Receptiveness of Stress Management Techniques by Military Personnel.* Stud Health Technol Inform., 144:125-7.)
- Saves # of clinicians; Saves time
- *“Virtual Reality for Psychology: Pricey up front for priceless results.”*
 - Hawaii Psychological Association (HPA), November 9 & 10, 2009, Ala Moana Hotel, Honolulu, Hawaii. Stetz, Folen, Meyers, Ganz, & Yoshioka, McDermott, & Koliiani, Miyahira, & Hladky.



Typical VR Design

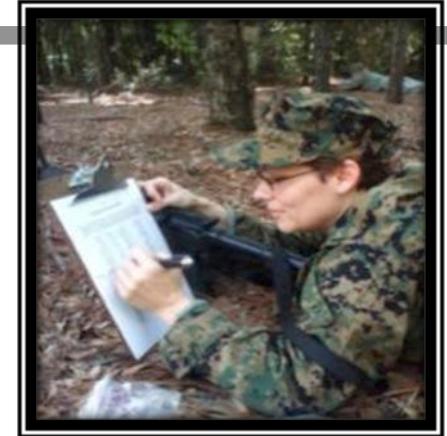
- **Participants ($\sim n = 60$)**
- **~ 2 groups (experimental and control)**
- **\sim Pre and post assessments and/or interventions**



Stressors' Assessment

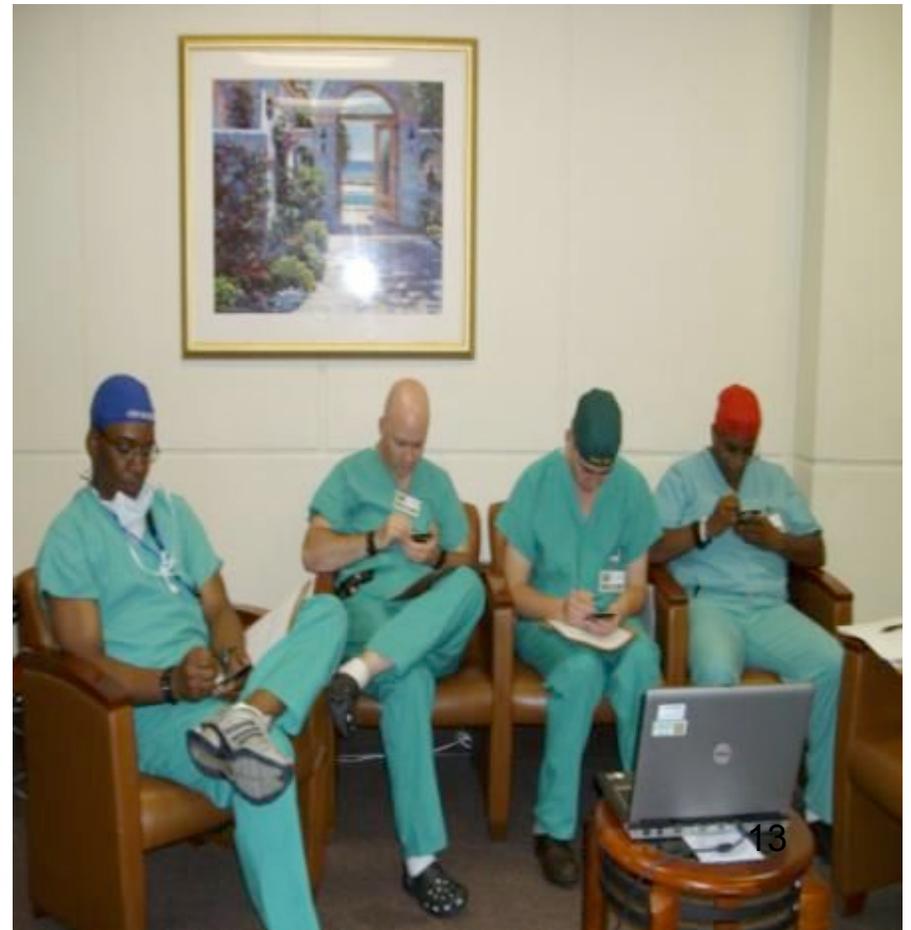
- **Paper and pencil batteries**
 - e.g., PTSD Checklist- Military Version (PCL-M)
- **Computerized batteries**
 - e.g., Automated Neuropsychological Assessment Metrics (ANAM)
- **Physiological systems**
 - e.g., Biofeedback; Salivary amylase

Paper & Pencil batteries

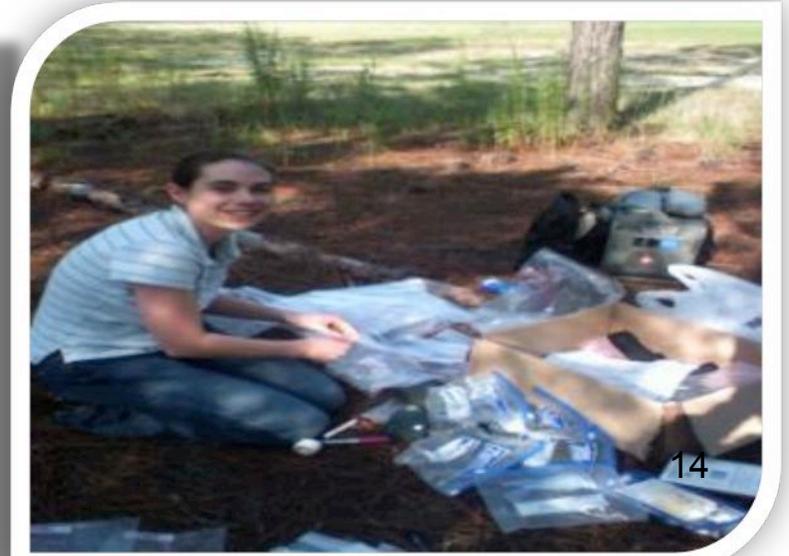
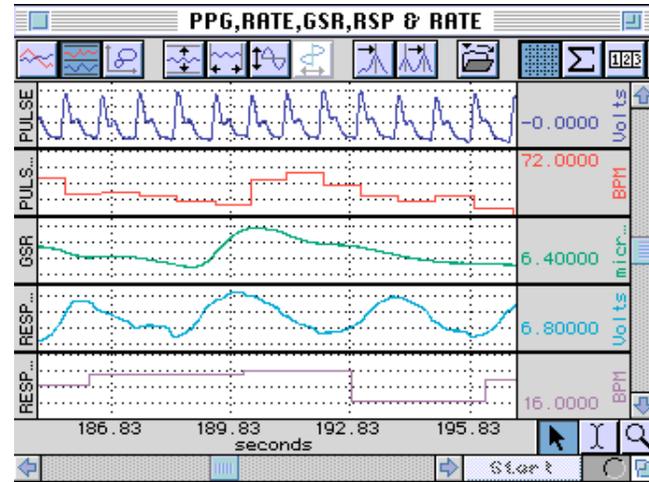


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Computerized Batteries



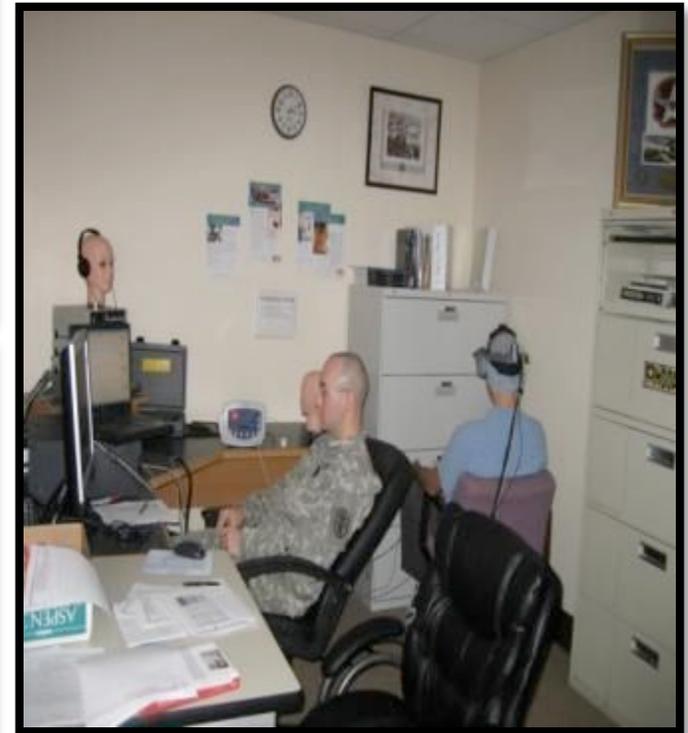
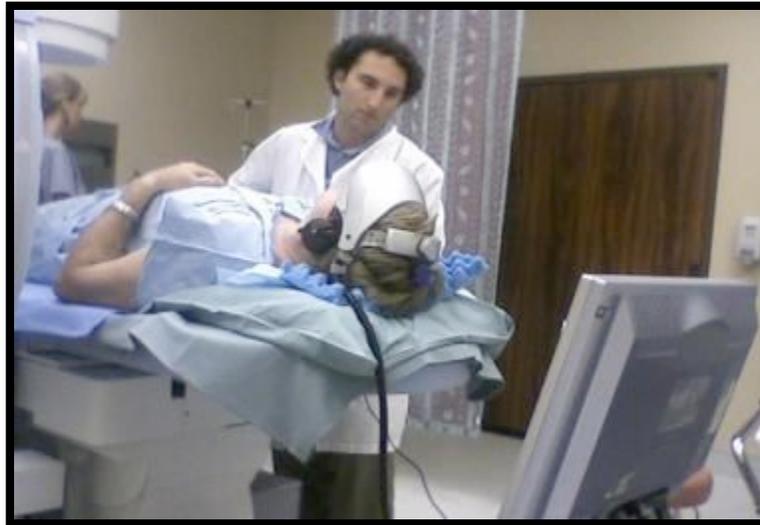
Physiological Equipment



Virtual Reality Equipment



Virtual Reality Equipment- cont.





Virtual Reality Equipment- cont.



Stetz, M. C., Bouchard, S., Wiederhold, B. K., & Folen, R. A. (2009). The Receptiveness of Stress Management Techniques by Military Personnel. *Stud Health Technol Inform.* 144:125-7.

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Conclusion



- Many warfighters are coming back from the war-zone with stress.
- Warfighters will go back to theater.
- Not many clinicians trained to work with the military.
- New generation of warfighters like videogames/computers.
 - System is “cool,” immersive, deployable, etc.





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The Israel Ministry of Defense (MoD) PTSD Survey

Miki Doron M.A. M.H.A

Oct 19, 2009



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The PTSD Survey

- Our vision:

Improving the condition of the MoD

PTSD patients through the improvement
of treatment and rehabilitation.

The PTSD Survey

Milestones:

- Annual collection of objective data regarding **patients' condition**
- Collection of data about the **treatments** given
- Statistical analysis to **gain insight** into the population and treatment characteristics

The PTSD Survey 2004-2009

Milestones (contd.)

- Developing **treatment guidelines for PTSD**, pre- and post- MoD recognition
- **Assessment of the application** of treatment guidelines and their affect on patient condition

PTSD Survey

Professional Counseling Board:

- CL. Dr. Gadi Lubin, Head of mental health dept. I.D.F.
- Dr. Jacob Polakevitch - Head of psychiatric services in the Health Ministry.
- Mr. Zeev Weissman - Head of Rehabilitation services in the Ministry's Rehabilitation Dept.
- Dr. Dan Dolfon - Head of medical services in the Ministry's rehabilitation dept.
- Miki Doron M.A, M.H.A - Meitan, Bar Ilan University

PTSD Survey

Professional Counseling Board:

- Prof. Zehava Solomon Tel Aviv University
- Prof. Avi Ohry Tel Aviv University
- Prof. Eli Witztum Ben Gurion University

The PTSD Survey – Questionnaires for Clinicians:

- Extensive demographic questionnaire
- Clinician Administered PTSD Scale for DSM IV
(CAPS)
- Montgomery-Asberg Depression Rating Scale
(MADRS)
- Hamilton Anxiety Rating Scale **(HAM-A)**
- "Bleich" **Disability Scale**
- Clinical Global Impression **(CGI) – Severity**
- Clinical Global Impression **(CGI) – Improvement**

The PTSD Survey – Questionnaires

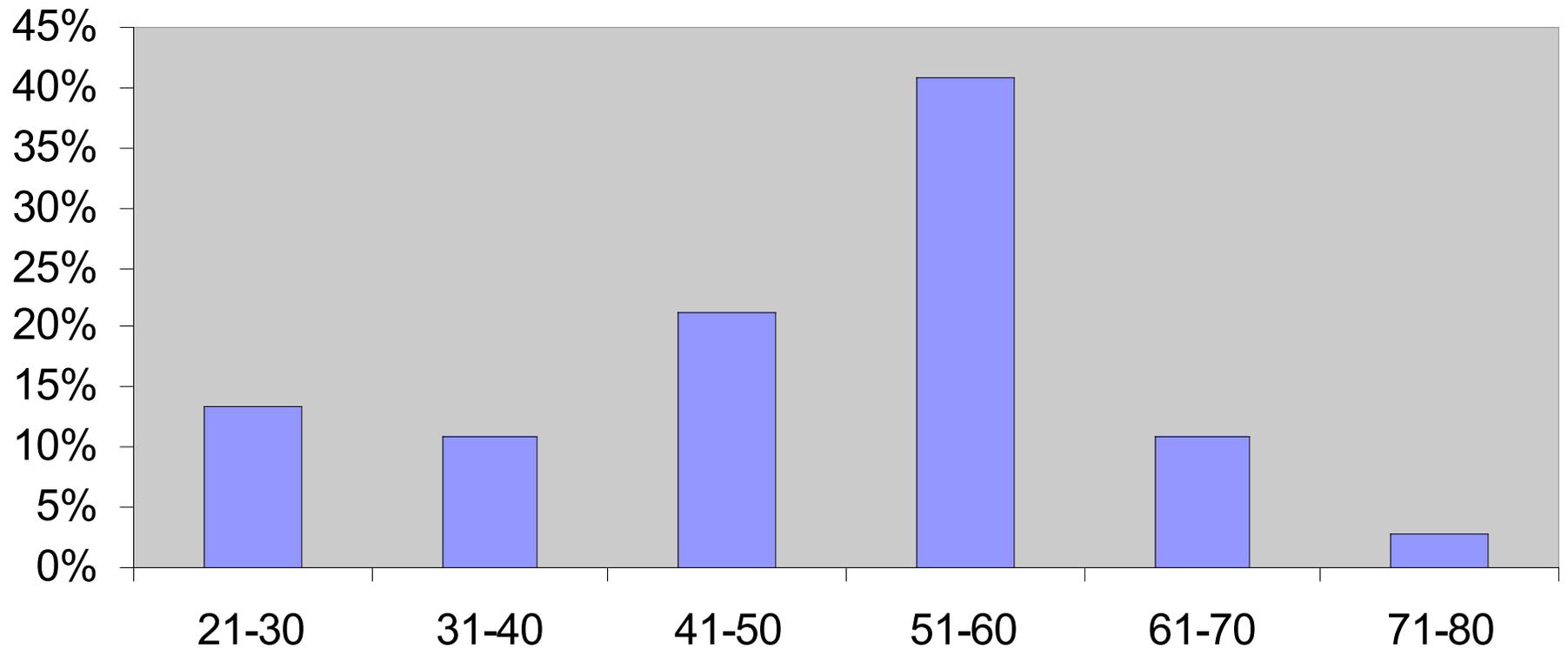
Self-report questionnaires:

- Personal Global Impression (PGI) –
Based on the CGI scale
- Quality of Life Scale (QoLS)

Patients' data

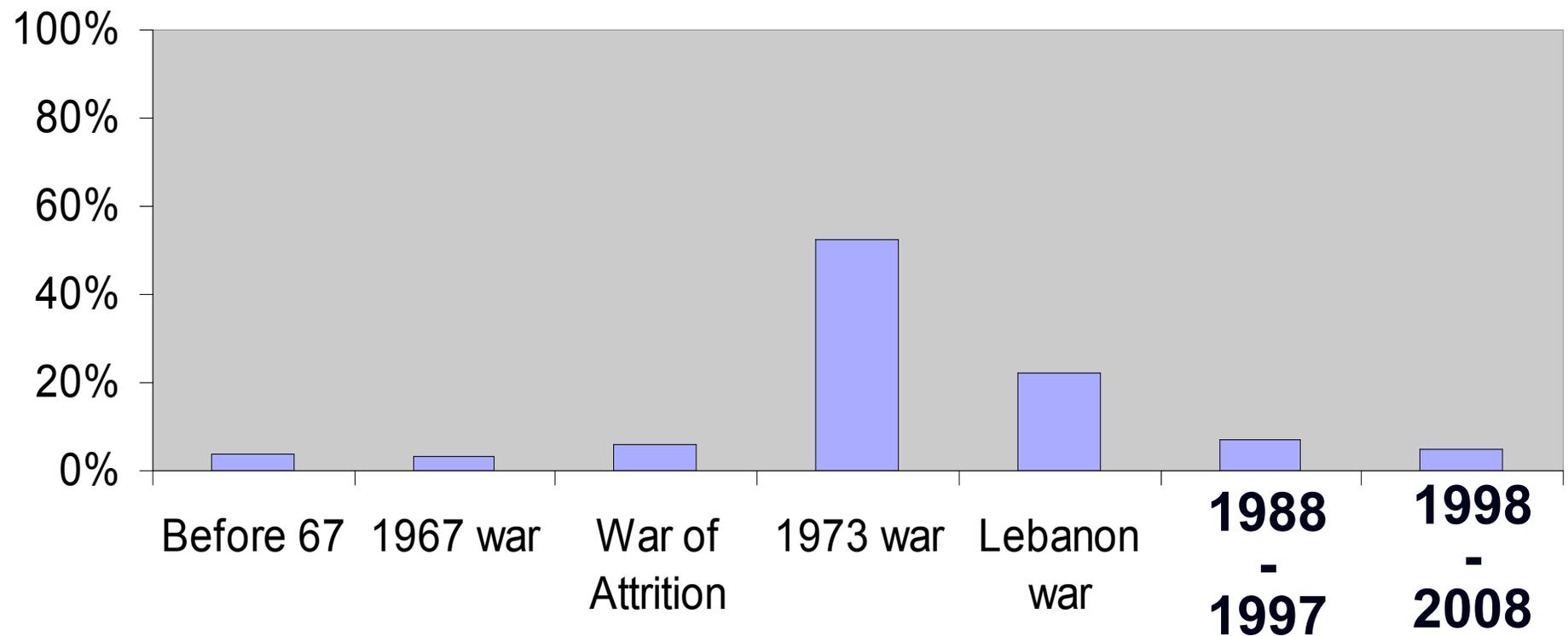
Age

Patients' Age Distribution



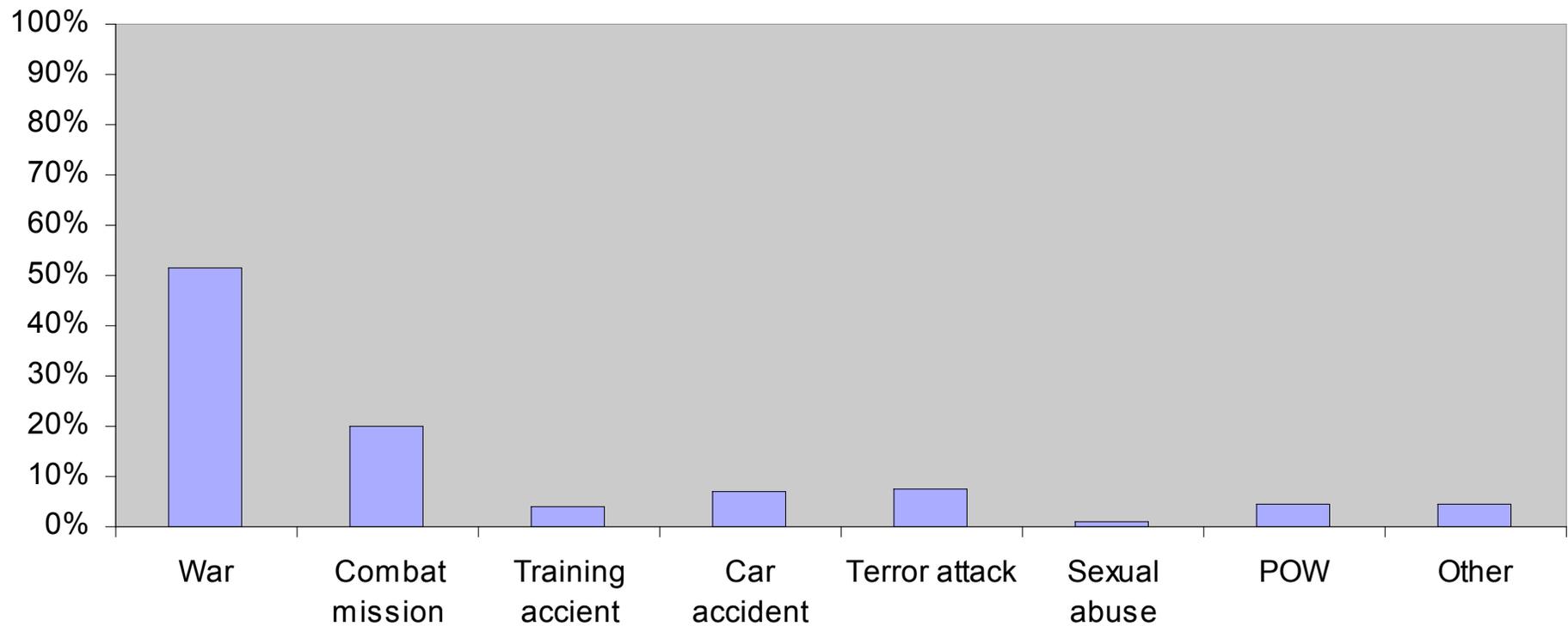
Wars Distribution

Wars Distribution



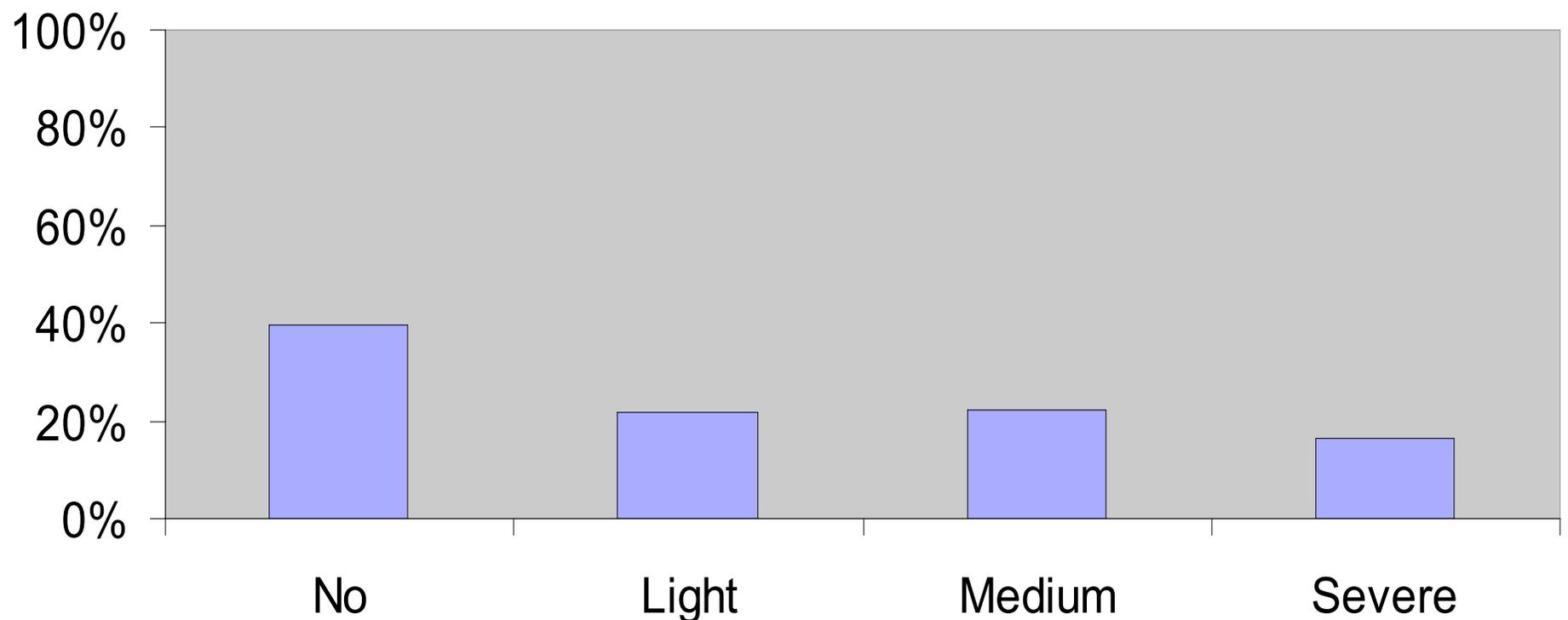
Traumatic Event

Event Distribution



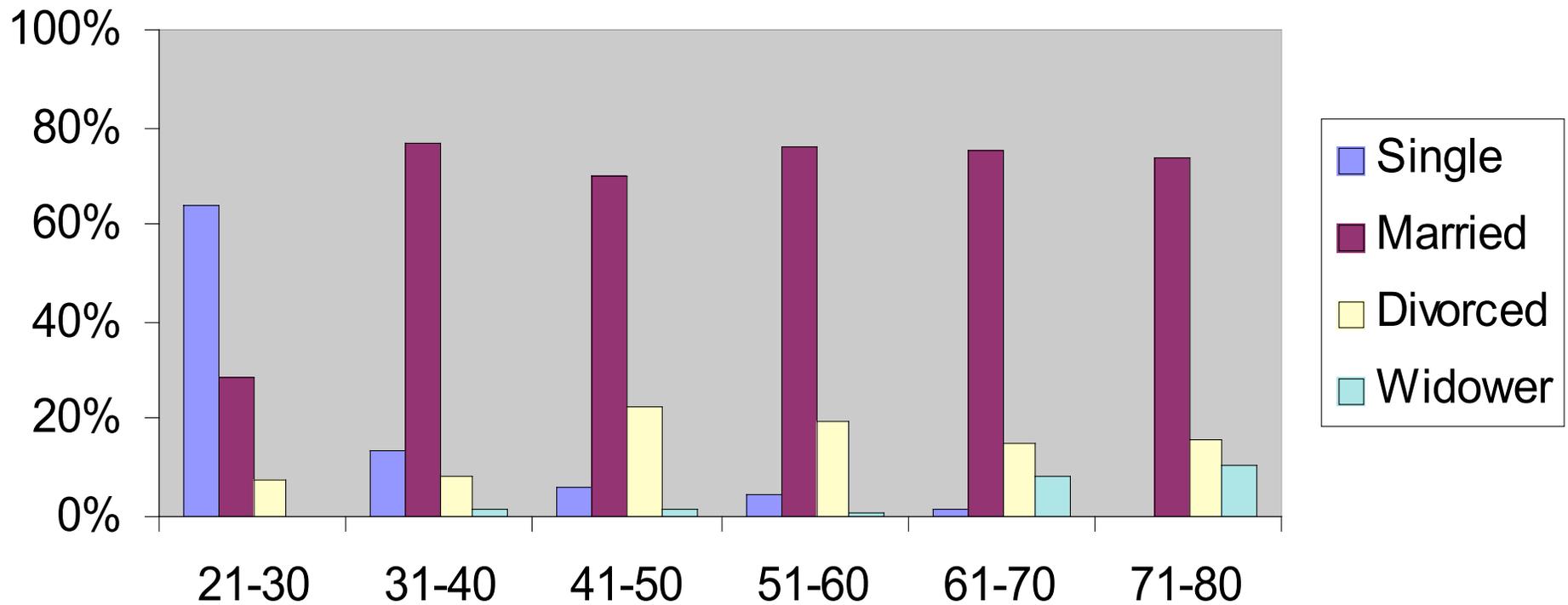
Combination with Physical Injury

Physical Injury During the Event



Marital status by Age

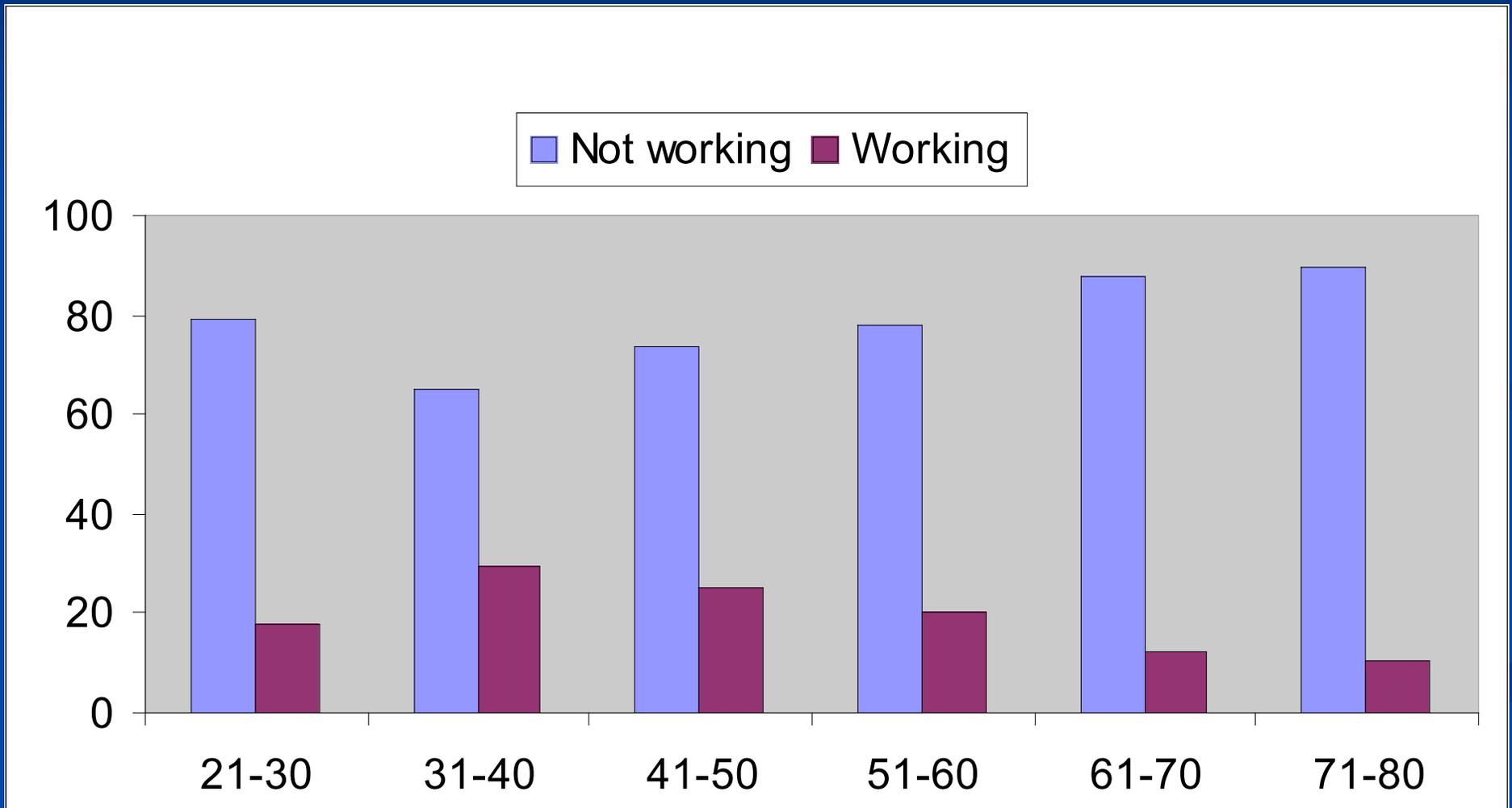
Marital status by age



Marital status among Israeli vs. US PTSD veterans

	N	Age	% married
Hartl et al., 2005 Palo Alto, CA, USA	630		36.5%
PTSD Survey , 2007 Israel	940	48.8	71%

Employment

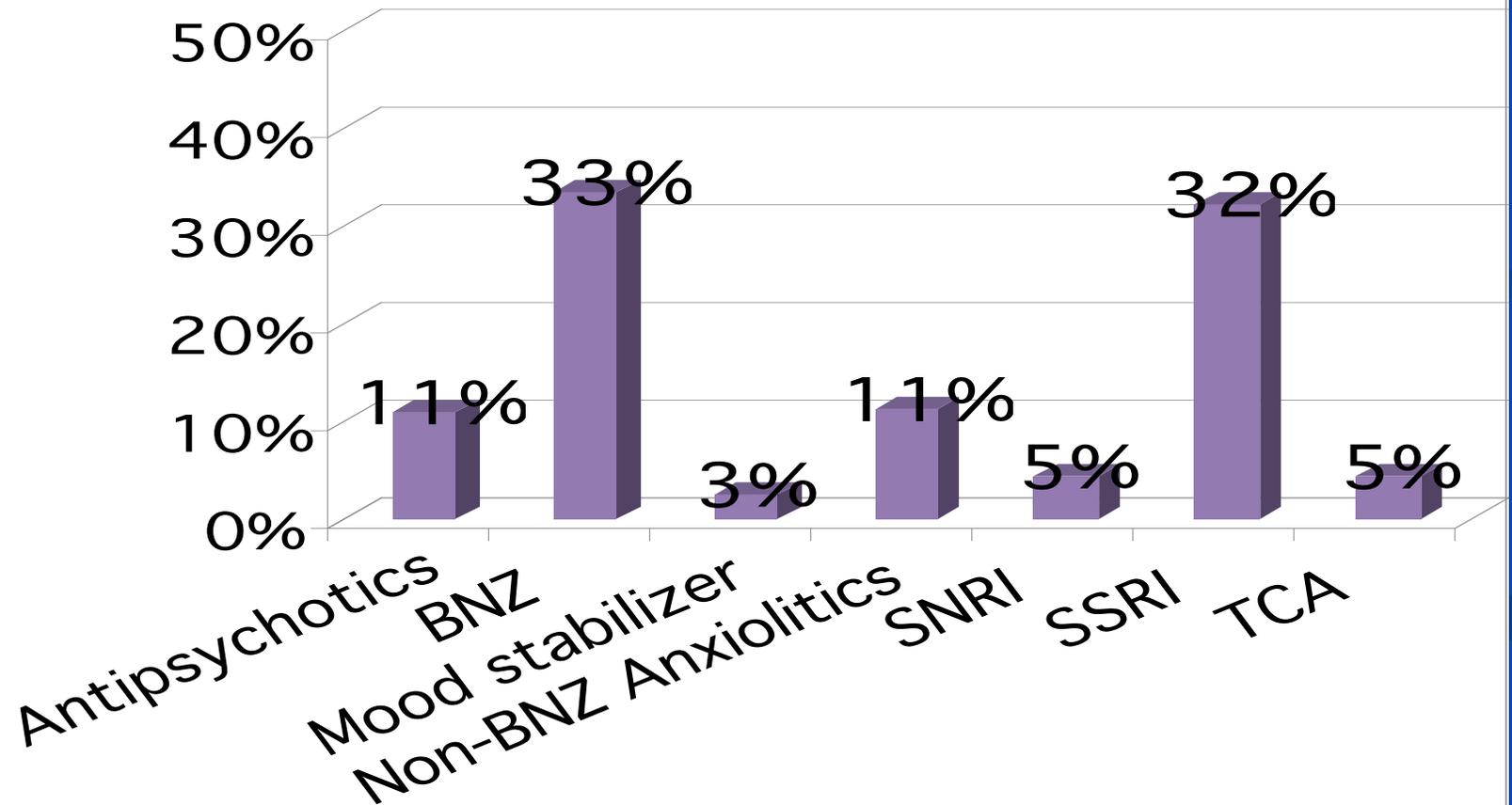


Treatments

Treatments

Pharmacology

Use Of Medications



Treatments

Psychotherapy

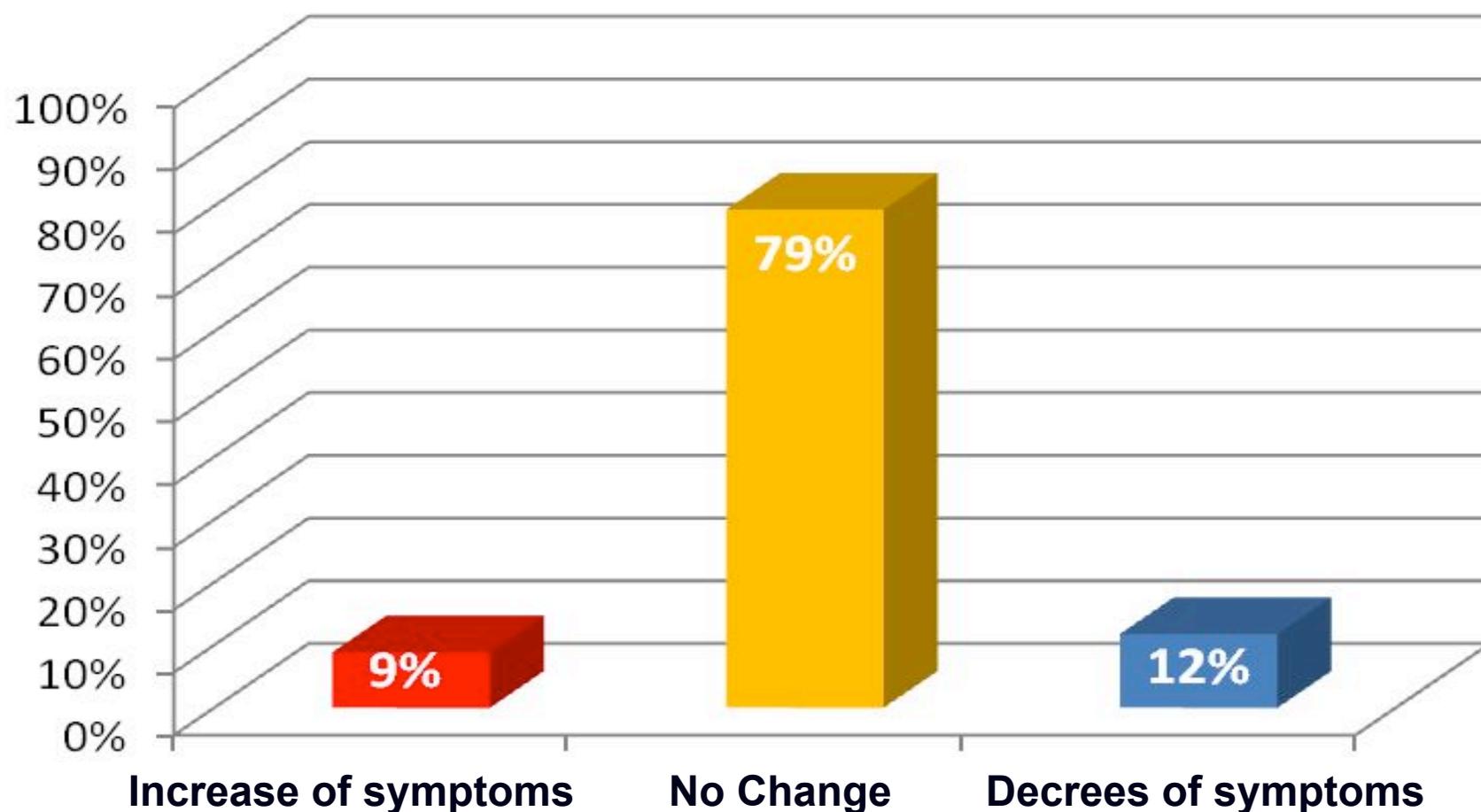
Psychotherapy Effect?

Surprising results:

No significant differences were found between different kinds of psychotherapy:

CBT - Dynamic - Integrative - Eclectic

Improvement Characteristics By CAPS from year 1 to year 3 (Example)



PTSD Survey

Clinical Guidelines

Israel MoD Clinical Guidelines

- Survey findings form the basis for the writing of the Israeli Clinical Guidelines for PTSD.
- The Clinical Guidelines was written by the advisory committee and other experts.
- The influence of the Clinical Guidelines' integration among Israeli MoD therapists treating PTSD will be examined in the near future.

PTSD Guidelines around the world

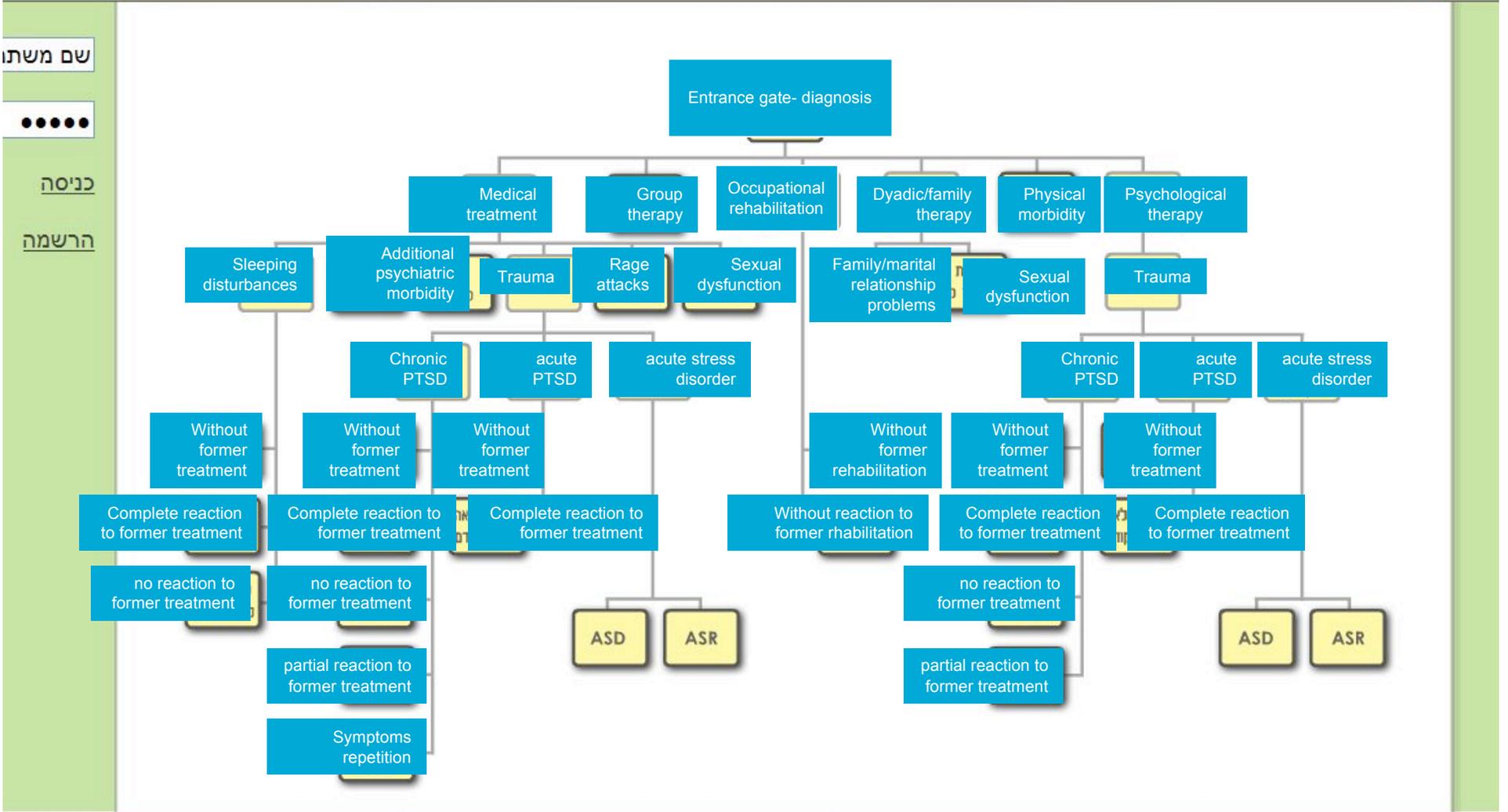
-  American Psychological Association (APA)
-  Veterans Affairs & Department of Defense (VA/DoD)
-  National Institute for Clinical Excellence (NICE)
-  International Society for Traumatic Stress Studies (ISTSS)
-  International Consensus Group on Depression and Anxiety
-  International Psychopharmacology Algorithm Project (IPAP) for PTSD
-  ECNP guideline for investigating efficacy of pharmacological treatment for PTSD

Israel MoD Clinical Guidelines

- Pharmacology treatment,
- Psychological therapy,
- Couple & sex therapy,
- Rehabilitative activity/education/HR,
- Accompanying physiological problems.

Israel MoD Clinical Guidelines

- Our clinical guidelines are **Patient-Oriented**
- They relate to:
 - Timescale – age of patient and length of illness.
 - Scale of illness severity and deficits in functioning.
 - Close environment axis – family or significant others.



Press on specific diagnosis to see the recommended treatment

- (severe 127 of 136) [Medical treatment for chronic PTSD with no former treatment](#) 1
 - (severe 127 of 136) [Psychological therapy for chronic PTSD with no former treatment](#) 2
 - [PTSD with sleeping disorder with no former treatment](#) 3
 - [PTSD with family/marital relationships problems](#) 4
 - [PTSD with sexual dysfunction- dyadic therapy](#) .5
 - [PTSD with sexual dysfunction-medical treatment](#) .6
 - [Medical problems](#) .7
 - (severe 86 of 95) [PTSD with employment dysfunction with no former rehabilitation](#) .8
 - [PTSD with Additional psychiatric morbidity \(dissociation\)](#) .9
 - [PTSD with Rage attacks and difficulty to control urges](#) 10
- To complete the diagnosis It is recommended to fill the next questionnaires:
- [HAMILTON – Assessment of Anxiety disorder](#) .1
 - [MADRS – Assessment of Depression disorder](#) .2

במידה והינך מעוניין לחזור לאבחון זה בעתיד, באפשרותך לשמורו בשם קוד. המידע לשימושך בלבד!



Save diagnosis

אבחנה

סיכום האבחון האינטראקטיבי מעלה את האבחנות הבאות (לחץ בכדי לראות את הטיפול המומלץ):

- 1. (moderate 108 of 136) Medical treatment for chronic PTSD with no former treatment
- 2. (moderate 108 of 136) Psychological therapy for chronic PTSD with no former treatment
- 3. (moderate 71 of 95) PTSD with employment dysfunction with no former rehabilitation
- 4. PTSD with sleeping disorder with no former treatment
- 5. PTSD with family/marital relationships problems
- 6. PTSD with sexual dysfunction- dyadic therapy
- 7. PTSD with sexual dysfunction-medical treatment

להשלמת האבחון מומלץ לענות על השאלונים הבאים:

- 1. HAMILTON – Assessment of Anxiety disorder
- 2. MADRS – Assessment of Depression disorder

במידה והינך מעוניין לחזור לאבחון זה בעתיד, באפשרותך לשמורו בשם קוד. המידע לשימושך בלבד!



Save diagnosis

2

אבחנה

סיכום האבחון האינטראקטיבי מעלה את האבחנות הבאות (לחץ בכדי לראות את הטיפול המומלץ):

- (mild 88 of 136) **Medical treatment for chronic PTSD with no former treatment** .1
- (mild 88 of 136) **Psychological therapy for chronic PTSD with no former treatment** .2
- (mild 42 of 95) **PTSD with employment dysfunction with no former rehabilitation** .3
- PTSD with sleeping disorder with no former treatment** .4

להשלמת האבחון מומלץ לענות על השאלונים הבאים:

- HAMILTON – Assessment of Anxiety disorder** .1
- MADRS – Assessment of Depression disorder** .2

במידה והינך מעוניין לחזור לאבחון זה בעתיד, באפשרותך לשמורו בשם קוד. המידע לשימושך בלבד!



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3

הקודם >>

To be continued

Thanks

Miki Doron MA MHA