CHAPTER 18

Canine Post Traumatic Stress Disorder (C-PTSD)

Background

MWDs exposed to different types of intense external stimuli, such as explosions and gunfire, experience a syndrome that is similar to PTSD in people. While much remains unknown about this syndrome, most of the affected MWDs to date have been exposed to these stimuli in combat scenarios. Thus, it is reasonable that MWD handlers will seek medical guidance for acutely affected dogs from HCPs. It is essential to be aware of this syndrome and to effectively guide handlers in immediate care while working to evacuate affected dogs to veterinary facilities. Veterinary Corps Officers are the best resource for current diagnostic and therapeutic recommendations and will facilitate telemedicine consultation with experts at the DoD Military Working Dog Veterinary Service.

High Index of Suspicion

Maintain high index of suspicion based on antecedent events. HCPs should maintain a high index of suspicion for C-PTSD so as to identify potential MWDs for further evaluation. Inclusionary criteria in the immediate period include antecedent events, specifically any combination of the following:

- Concussive event (with or without physical injury)
- Exposure to a combat environment, and
- Prolonged or repeated deployment to combat zone.

Key Behavioral Signs Characteristic for C-PTSD

Specific behavioral signs are tip-offs that C-PTSD may be present. HCPs will need to rely on the MWD handler for information about these signs.

Signs include any combination of the following: escape or avoidance from work-related environments, increased or decreased reactivity to environmental or social stimuli, positive or negative changes in rapport with the handler, or interference with critical tasks (detection, controlled aggression, and obedience).
NOTE: Possible delayed onset or delayed reporting of clinical signs supporting C-PTSD is common.

Although MWD handlers will most likely seek guidance after acute onset of signs, HCPs should be aware some MWDs may not manifest obvious signs for some time, or handlers may not seek guidance until the syndrome is advanced. Additionally, some dogs will have been evaluated, with treatment initiated by veterinary personnel, with handlers seeking guidance some time later. Thus, other keys to C-PTSD for HCPs to be aware of are the continuance of behavioral signs for more than 30 days and failure to improve with time or treatment.

Rule Out Problems Mimicking C-PTSD

Some medical problems cause signs that mimic C-PTSD. HCPs should carefully evaluate dogs for exclusionary criteria, such as traumatic brain injury (See Chapter 17). A key tip-off that C-PTSD is likely not present is development of behavioral signs before the antecedent events noted previously. Veterinary personnel must rule out anecdotal reports and other appropriate behavioral diagnoses in order to validate a C-PTSD diagnosis.

Management Guidance for HCPS

Listen to the MWD handler! If a handler seeks guidance for his or her working dog due to abnormal behavior in the first 30 days after a traumatic event or combat action, HCPs should do the following:

1. Record the interaction and forward to supporting veterinary personnel (See Chapter 22).
2. Direct the handler immediately remove the dog from the situation, if not already done.
3. Upon approval from the supporting veterinary officer, provide an anxiolytic for dogs that have demonstrated a moderate-to-severe response, using one of the following agents, given PO (preferable), IV, or IM:
   - Clorazepate (TRANXENE®), 12.5 mg per dog PO q12h (moderate response)
   - Buspirone (BUSPAR®), 10-20 mg per dog PO q8-12h (moderate to severe response)
   - Alprazolam (XANAX®), 1-2 mg per dog PO q12h (moderate to severe response)
4. Direct the handler to provide support for the dog with social activity and play.
5. Direct the handler to provide work therapy by performing critical tasks in safe area, free from distress.
6. Recommend to the handler and the commander that the MWD not be used in the tactical environment until the dog has been evaluated by veterinary personnel.
7. Coordinate soonest evacuation to veterinary personnel for further evaluation and care, base on the tactical situation and resource availability. MWDs with C-PTSD should be classified as ROUTINE for evacuation planning purposes.

Long-term Management

There is no role for HCPs to attempt long-term or delayed management of presumed C-PTSD. Misdiagnosis and/or delay of appropriate treatment will equally jeopardize the affected MWD's proper therapy and potential of return to duty. Affected dogs should be evaluated under the supervision of Veterinary Corps Officers and through consultation with the DODMWDVS board-certified animal behaviorist. On-going research suggests a positive association with early diagnosis, +/- medication and focused desensitization/ counterconditioning performed by the MWD handler in the first 60-90 days of case management. Every attempt is made to return the MWD to duty and avoid unnecessary STRATEVAC/redeployment, which can result in security and readiness issues.

C-PTSD References

1. Overall KL, Burghardt, WF. Report of the Blue Ribbon Panel on Post-Traumatic Stress Disorder in Military Working Dogs. Department of Defense Military Working Dog Veterinary Service, Lackland Air Force Base TX, 2011.

2. Burghardt WF, Broach, DR. Canine Post-Traumatic Stress Disorder (C-PTSD) in Military Working Dogs. American Veterinary Medical Association, San Antonio TX, 2016.