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Mental Health Update - August 18, 2009

Attached is an article from the Therapy Times about veterans and PTSD. Helena Davis, MHANYS Director of Training, has done a great deal of work in this area and said that this article was 'the most complete and concrete that she has seen.'

Glenn

Fighting the War Within - Veterans struggling with post-traumatic stress disorder

By [Bob Stott](#), 08.17.09, *Therapy Times*

Intense training is demanded of today's American soldier. They are drilled to be constantly alert, vigilant for enemy attack from rooftops and side alleys, to be wary of innocuous containers on the side of the road, to be suspicious of everyone not dressed in their uniform. In a combat zone, soldiers are trained to ignore extreme stress, weather, and pain, and, when necessary, soldiers must be able to kill.

After months in a hostile environment, this training becomes second nature to a soldier; it becomes the hardwired behavior that keeps them alive for the months of their deployment. Now, as hundreds of soldiers are returning to the United States from tours of duty in Iraq and Afghanistan, another problem is coming to light - how do they turn their training off?

Many soldiers in combat adopt a "battle-ready" mind frame as a way to cope with the constant stresses of their deployment. Rapidly switching between a civilian mentality - with concerns for career, education, or family - and a soldier mentality in a combat zone will only increase psychological distress, so the unconscious mind reprioritizes the skills and behaviors that will ensure daily survival. However, even in a battle-ready state of mind, the mind is not impervious to the horrors of war.

Unlike previous wars, deployment in the urban settings of Iraq and Afghanistan present more severe stressors to the soldier. The experience of engaging enemy combatants at close range is a frequent occurrence as soldiers push through towns and cities. Also, extended lengths of service with only short periods of rest and recuperation in between are taking a psychological toll on many soldiers.

Post-traumatic stress disorder (PTSD) is quickly becoming a leading disability among returning soldiers, with approximately 20 percent of veterans diagnosed. Plagued by flashbacks and nightmares, increased arousal, hypervigilance, and difficulty sleeping, returning soldiers are experiencing significant barriers to slipping back into a civilian lifestyle.

What Lies Beneath

A prominent challenge that healthcare professionals are facing with returning soldiers is differentiating between PTSD and mild traumatic brain injury (TBI), in which the soldier receives a relatively mild blow to the head that impairs memory, attention, mental organization, and logical thinking. Both of these conditions exhibit similar symptoms and are signature medical problems for soldiers coming out of Iraq and Afghanistan.

“There are a lot of similarities between PTSD and TBI,” says Paula Zemaitis, OTR, an occupational therapist at Sacred Heart Hospital in Eau Claire, Wis. “For example, both of these conditions can manifest through aggressive behaviors. Also, there is usually an inability to concentrate, headaches, social isolation, increased incidence of substance abuse, difficulty learning and assimilating new information, and increased distractability.”

She continues: “Many times, we are waiting to see if some of these symptoms resolve, or rather not resuming, because head injuries tend to move through phases - an initial aggressive period but gradually they move through and progress with their therapy. If the patient does not seem to be progressing through those stages, then the therapists have to ask if this could this be something more - could this be post-traumatic stress disorder?”

While in the past, it was thought that one could not suffer from both PTSD and TBI, the combat situations American troops are faced with in the Middle Eastern war zones have made this combined injury much more common. Especially with many American soldiers seeing repetitive tours of duty in Middle Eastern “hot spots,” several are seeing traumatic situations multiple times and increasing the possibility of receiving a TBI as well.

“When we look at these patients, it’s also important to remember that many patients have both PTSD and TBI so the symptoms can be compounded,” says Carol O’Brien, PhD, chief of the PTSD Program at Fla.-based Bay Pines VA Healthcare System. “Obviously if someone has a traumatic brain injury, there is something that has occurred to cause the injury, and that event, whether it’s an explosion or another kind of injury, can also be traumatic from a psychological standpoint. So there’s an issue of overlap between PTSD and TBI.

“When we’re trying to distinguish between them, we often look for symptoms that are unique to either TBI or PTSD - sometimes that helps us and sometimes not,” says O’Brien. “For instance, we look at things like headaches, when we’re looking to determine whether this is more related to TBI than PTSD. Some of the more somatic symptoms - tinnitus, the ringing in the ears, for example - are very classic for TBI but not typically found in PTSD. And on the other side, we look for things like nightmares, which is certainly more classic for PTSD than it is for TBI.”

The Disconnect

When soldiers return home, many find themselves changed from who they once used to be. The rigid combat training that allowed them to survive in the urban war zones of Iraq and Afghanistan has no place in the civilian sector - but that does not mean that training dissipates. Veterans may feel alone without other soldiers, whom they have come to know as family, being near by. Many soldiers do not feel comfortable speaking with family and friends about what they have gone through, as they were not there and will simply not understand.

“Soldiers getting together with their buddies, talking to their peers, talking to their

commander is the first line of defense - soldiers need to open up those lines of communication,” says Zemaitis.

“Many times the soldiers can’t share what they’ve seen with their family members. They can’t share what they’ve been through. They go out with friends, who are talking about what they’ve done in the last five years, while the soldier been overseas fighting and relatively isolated from anything that’s non-military. It takes a while to work back into a social situation, whether it’s with family or friends.”

While there is considerable training for going into a war zone, the same does not apply for coming home again. Soldiers are expected to decompress on their own, but often this “leave” only provides a vent for the suppressed trauma of combat. Many times, the spouse of a soldier recently returned from active deployment will feel distant from them; they feel as though they are no longer connecting or communicating.

Civilian life can easily become a minefield of irrational outbursts and traumatic episodes - for a soldier trained to counter sudden attacks, a mall crowded with people or a cardboard box on the side of the road can trigger the “battle-ready” mind set.

“What we’re educating family members on are the soldiers that have recurrent headaches, those that wake up in the middle of the night, those that are real jumpy at home - they have a low patience level,” says Zemaitis.

“I like to think of the incident of road rage. We all get in traffic, but that particular person is more heightened and ready to get aggressive a little more quickly, ready for confrontation. Those individuals also have a hard time dealing with their peer group because a lot of their peers are still overseas. Fitting back into society, many times you find higher incidences of substance abuse, people self-medicating because they just don’t fit in quite so easily any more,” says Zemaitis.

Soldiers to Citizens

Soldiers are highly skilled at ‘toughing it out’, regardless of the problem. There is a prevailing warrior mentality among many returning soldiers with PTSD - quite simply, treatment is for the weak and they don’t need it. In comparison to the amputated limbs, severe burns, and permanent blindness suffered by others in military hospitals, many soldiers feel that a few nightmares and panic attacks are problems hardly worth verbalizing.

“Therapy for PTSD begins first, of course, with a thorough assessment, but also a focus on what are the soldier’s goals,” says O’Brien. “Some people come into treatment or therapy really looking for a solution to some of the PTSD symptoms. Others come in with relationship difficulties primarily, or with issues around anger primarily, and so on. So the first thing we do is assess where the veteran is and where they want to go with all of this.”

When treating PTSD, healthcare professionals tend to rely on two common forms of treatment: prolonged exposure and cognitive processing therapy. In cognitive therapy, the therapist helps patients understand and change how they think about their trauma and its aftermath. Patients learn to identify thoughts about the world and themselves that are causing them anxiety; with professional help, patients can learn to replace these thoughts with more accurate and less distressing thoughts.

In exposure therapy, the goal is to have less fear about memories. It is based on the idea that people learn to fear thoughts, feelings, and situations that remind them of

a past traumatic event. By talking about your trauma repeatedly with a therapist, patients learn to get control of their thoughts and feelings about the trauma.

“These treatments involve really looking at the trauma itself: specifically, what happened,” says O’Brien. “When something traumatic occurs, whether it’s war-related or natural disasters, it’s actually a very normal human response to want to put it away, to not think about it, to avoid things that remind you of it. Treatment that directly addresses the trauma reverses that and helps the veteran or the soldier to access those memories and thoughts about the traumatic event to be able to come to talk about it, to think about it, without the intense distress.”

She adds: “Soldiers are eager to be able to live their life again by going back to the movies, and doing things with family members, and being able to go to the supermarket, and tolerate being in a crowd of people, to be able to drive down the street and not get distressed and distracted by things on the side of the road. Treatment involves both the ability to tolerate and live with and deal with the internal experiences that people have when they’ve been exposed to trauma, and also to, once again, reconnect and reintegrate into their lives.”

In an effort to curtail the number of soldiers returning to civilian status with PTSD, the Walter Reed Army Institute of Research has devised a training program called “Battlemind Training” to acclimate soldiers to a peacetime environment. In particular, the program is intended to ease soldiers’ adjustment to their families and communities - transitioning combat skills to fit civilian life. For example, behavior such as combat driving in the middle of the road or constantly being armed, needs to be eased into appropriate driving and gun-possession laws.

Among soldiers who returned from Iraq and participated in the program, fewer reported sleep problems and exhibited less-severe post-traumatic stress disorder symptoms, compared with soldiers who had received either no post-deployment mental health training or a briefing about stress. Studies following the participants found that in soldiers who had seen extensive combat, “Battlemind training” resulted in a 14-percent reduction in severity of post-traumatic stress disorder symptoms.

As coalition forces work toward reconciliation in the Middle East, it lands on the shoulders of our healthcare and therapeutic professionals in both the military and civilian sectors to see that that these young men and women do not also become victims to the psychological aftermath of war.

- Bob Stott is an editor for Therapy Times. Questions and comments can be directed to bstott@therapytimes.com.

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