The war that never ends(veterans)

Government, Army

The War that Never Ends- Soldiers suffering with Post Traumaticstressdisorder The impact of deployment and especially war-zone experiences on the well-being of military personnel and veterans continues to receive growing attention. The military operation in Iraq and Afghanistan continues to raise important questions about the effect of the experience on the mentalhealthof members of the military services who have been deployed there (Hoge et al. , 2004). Combat exposure has been linked to an array of negative health consequences, most notably posttraumatic stress disorder (PTSD).

According to the DSM-IV-TR, PTSD is ananxietydisorder that can develop in a person after a traumatic experience in which " the person [has] experienced, witnessed, or [been] confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of [one]self or others. According to the Surgeon General, of those individuals experiencing extreme traumatic events, nine percent develop PTSD. Approximately 50% of those cases will return to a normal mental health state in less than a year.

After one year, women were twice as likely to continue with symptoms of traumatic stress. Sometimes dubbed emotional mental health disorders such as acute stress, depression, anxiety and posttraumatic stress disorder (PTSD) are common by products of military combat (Soldiers’ Mental Health, 2007). During the current U. S. -led war onterrorisma campaign initiated following Sept. 11, 2001, attacks against U. S. - tens of thousands of soldiers deployed to Afghanistan and Iraq have been diagnosed with such conditions

(Soldiers’ Mental Health, 2007). While some military veterans seek medical treatment after they return to the U.

S. , many do not, beginning what often becomes a life long battle with mental illness (Soldiers’ Mental Health, 2007). Furthermore, the individual's " response involved intense fear, helplessness, or horror. ” The individual must also experience at least one symptom of intensive recollections, at least three symptoms of avoidance/numbing, and at least two symptoms of hyper arousal. Symptoms of hyper-arousal include sleep problems, irritability, concentration problems, hyper-vigilance, and exaggerated startle response. All symptoms must be present for one month or longer.

In order for PTSD to be diagnosed as a disorder, " clinically significant distress or impairment in social, occupational, or other important areas of fractioning" must be present. PTSD received official recognition and a separatediagnosticheading with the DSM-III publication in 1980. However, the symptoms of PTSD have been recognized for centuries. During theCivil War, generals noted that the troops were suffering from " irritable heart" or " effort syndrome," in World War I the diagnosis was " shell shock," and in World War II it was called " battle fatigue" or " combat exhaustion.

In modem engagements such as Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), symptoms of PTSD are denoted " acute stress," perhaps in an effort to reduce stigma among deployed troops. Whatever its appellation, it is deemed a " signature wound" of the Iraq and Afghanistan engagement veterans. Therefore, military personnel are among the most at-risk populations for exposure to traumatic events and the development of PTSD. Ethnic minority Veterans may be more likely to

disclose problems or engage in treatment when paired with a clinician of the same race (Loo, 2007).

Despite study differences, the trend suggests that being an ethnic minority may cause one to be more " at risk" for PTSD (Loo, 2007). The National Vietnam Veterans Readjustment Study found differences among Hipic, African American, and White Vietnam theater Veterans in terms of readjustment after military service (Loo, 2007). Both Hipic and African American male Vietnam theater Veterans had higher rates of PTSD than Whites (Loo, 2007). Rates of current PTSD in the 1990 study were 28% among Hipics, 21% among African Americans, and 14% among Whites (Loo, 2007).

African Americans had greater exposure to war stresses and had more predisposing factors than Whites, which appeared to account for their higher rate of PTSD (Loo, 2007). The difference in rates of PTSD between Hipics and Whites remained even after controlling for the fact that Hipics had greater exposure to war stresses (Loo, 2007). Rates of PTSD among American Indian Vietnam Veterans ranged from 22% to 25% (depending on the tribe) (Loo, 2007). American Indians were exposed to greater war zone stresses (e. g. atrocities, violence, and combat) than Whites, including psychological conflict resulting from identification with the enemy (Loo, 2007). Differences in PTSD rates between American Indians and Whites disappeared after controlling for the greater war zone stresses experienced by American Indians (Loo, 2007). Unfortunately, there continues to be an ongoing supply of combat- traumatized soldiers to study. As noted by Coleman (2006), war

is a disease that kills and maims, not just by tearing apart soldiers’ bodies, but also by ravaging their minds.

As the United States continues a military presence in Iraq and Afghanistan, it is also coming to grips with one of the products of war at home: a new generation of troubled veterans. Hoge, Auchterlonie, and Milliken (2006) emphasize that research with active duty personnel in Iraq and Afghanistan suggests that this new generation of veterans has high levels of PTSD and related mental health symptoms. Studies are demonstrating that troops who serve in current conflicts are experiencing PTSD and other mental health problems on a scale not seen since the war in Vietnam (Robinson, 2004).

PTSD prevalence is widely disputed in medical literature, particularly its predominance among military personnel. However, " approximately 8% of the [general] population meets criteria for PTSD during their lifetime. PTSD Stressors in the general public are often the result of a traumatic event (violent crime, accident, etc.). With regard to military personnel, the range of estimates is wide—" PTSD is the most prevalent mental health disorder among deployed service members, and affects roughly 5 to 15% of service members, depending on who is assessed and when they are assessed. From October 2001 to April 2008, approximately 1. 4 million U. S. troops had been deployed in OEF/OIF engagements. As of October 2009, more than 2 million men and women had shouldered the deployments, with 793, 000 of them deploying more than once. Nearly 40% of OEF/OIF veterans had multiple deployments, and multiple " combat" exposures. Even at the low end, a 5% incidence of PTSD among deployed veterans would equal 100, 000 OEF/OIF veterans with PTSD. However, this 5% is questionable on broader

assessment, and most likely an underestimate. Using Veterans Affairs (VA) data, 23% of OEF/OIF veterans seen at the VA received a preliminary diagnosis of possible PTSD.

Further analysis of the same data shows that only half of these PTSD patients had approved PTSD claims. Therefore, about 50% of OEF/OIF veteran patients receiving treatment for PTSD from the VA were not receiving compensation, and hence are likely undercounted as victims of PTSD. In addition, since approximately 40% of service members are still active on active duty, considering active duty military PTSD cases is also instinctive. Surveys of deployed Army soldiers and Marines show between 14% and 17% met screening criteria for PTSD while they were deployed between 2003 and 2006.

This data lends additional support to the proposition that the estimate of 5% prevalence of PTSD is empirically low. The United States has incurred massive human and financial expenditures through its involvement in Iraq. It is estimated that total spending on the Iraq war will cost the United States up to $3 trillion to fund current military operations along with the expenses of paying the long-term disability costs of injured military personnel, death benefits sent to the families of those killed in Iraq, and interest fees paid by the United States Treasury to borrowmoneyto fund current expenditures (Bilmes ; Stiglitz, 2008).

The National Center for PTSD embraces the customary treatment strategy for PTSD as being symptom logically based. As such, individuals diagnosed with depression and anxiety receives pharmacologic treatment, in addition to the use of cognitive behavior therapy to help individuals with cognitive

deficits (Summerall, 2008). Cognitive behavior therapy usually includeseducationregarding the stress response and relaxation techniques in efforts to enable the individual to exercise control over the extreme physical reaction to PTSD triggers and engage completely in therapy, overcoming avoidance symptoms.

Case management, psychosocial rehabilitation, pharmacotherapy, and psychotherapy are all viable components and options regarding treatment and care provision for individuals who have incurred PTSD (Kennedy et al. , 2007). When it comes to medication management, special attention should be paid to possible drug interactions in individuals diagnosed with PTSD. These individuals may be taking medications for various symptoms such as pain, insomnia, and dizziness, in addition to surgery-associated anesthesia and antibiotics.

Fluid changes resulting from procedural treatment of burns, amputations, wounds or internal organ injuries can dramatically affect the action and interaction of drugs. Moreover, individuals with PTSD may be hypersensitive to medicinal effects and corresponding side effect. Medications have proved helpful to treat depression, seizures, and agitation among persons with PTSD (Perna, Rouselle, ; Brennan, 2003).

However, antipsychotic medications should be used with caution given their potential to increase negative neurobehavioral symptoms (Rosenthal ; Ricker, 2000). Impaired recall and attentiveness resulting from PTSD can also complicate medication management, as an individual may have difficulty accurately following dosage recommendations (Kennedy et al. , 2007). Furthermore, New Treatment Modalities recognize the need to meet the

unique needs of military personnel with PTSD, the United States Government is exploring a variety of new treatment models.

For example, the Office of Naval Research funded a $4 million project in 2005 to study the efficacy of virtual reality treatments for PTSD, which is being tested in universities and military installations across the United States (Bergfeld, 2006). This treatment involves the person experiencing virtual reality situations (i. e. , guiding them through a military compound in Fallujah or going on patrol through homes of Iraq citizens). The therapist monitors the veteran’s responses (e. g. , breathing, sweating) and then teaches the veteran how to remain calm and composed through the use of meditation.

The hope is that that the client can generalize this skill to prospective high stress situations in the real world (Bergfeld), ultimately leading to a reduction in the occurrence of PTSD symptoms. PTSD can make somebody hard to be with; living with someone who is easily startled, has nightmares, and often avoids social situations can take a toll on the most caringfamily(U. S. Department of Veteran Affairs, 2010). Family member may feel hurt, alienate, or discouraged because your loved one has not been able to overcome the effects of the trauma (U.

S. Department of Veteran Affairs, 2010). Social support is extremely important for preventing and helping with PTSD, it is important for family members to take care of themselves both for their own good and t help the person dealing with PTSD (U. S. Department of Veteran Affairs, 2010). Veterans with PTSD and their families can access several other resources associated with rehabilitative assistance. Active duty service members and

their families are eligible to utilize health care services through Tricare, or Triwest depending on geographic region.

Services are available on base from military providers, as well as through private care providers who require a co-payment. Also available to active duty members is Military OneSource, which provides a maximum of six free counseling sessions for service members and their families. Military OneSource has licensed counselors available 24 hours a day, seven days a week, and also serves as informational resources, addressing topics such as relocation and finances (Fairweather ; Garcia, 2007). Veterans with PTSD often have other types of problems (U. S. Department of Veterans Affairs, 2010).

They might have other stress, medical or mental health problems. Sometimes PTSD is overlooked when other problems seem very pressing (U. S. Department of Veterans Affairs, 2010). In Addition, a number of community organizations have been established to assist veterans and their families with adjustments to daily living brought about by combat incurred injuries such as PTSD. Swords to Plowshares, Veterans for America, and Veterans and Families exemplify groups that offer a wide range of information, resources and services (Fairweather ; Garcia, 2007).

The Marine Corps Community Services, The Coming Home Project, Operation First Response are some of the Internet-based health, family, employment and education, and benefit, advocacy, and general resources to meet the needs of veterans with PTSD and their families compiled from research (Fairweather and Garcia (2007, Yeoman, 2008). According to the U. S. Department of Veterans Affairs (VA), the VA provides nearly 200 specialized

PTSD treatment programs referral is usually needed (U. S. Department of Veteran Affairs, 2010).

Each PTSD program offers education, evaluation, and treatment, some of the program services include: One to one mental assessment and testing, medicines, one to one psychotherapy and also family therapy, and group therapy which covers topics such as anger and stress, combat support, partners or groups for Veterans of special conflicts (U. S. Department of Veteran Affairs, 2010). The VA also offers specialized outpatient PTSD programs (SOPPs) and specialized intensive PTSD programs (SIPPs).

Congress has in fact passed some notable legislation aimed directly at improving mental health care and quality of life for combat veterans (Wilcox-Fogel, 2012). The Caregivers and Veterans Omnibus Health Services Act of 2010 provides financial support for family members of injured veterans who are now responsible for caring for their loved ones who have returned with lifelong disabilities (Wilcox-Fogel, 2012). The VOW to Hire Heroes Act provides tax credits for businesses hiring veterans and is an important step in working to lower the alarmingly high veteran’s unemployment rate (Wilcox-Fogel, 2012).

The COMBAT PTSD Act has died in two previous sessions of Congress and remains in committee in the current legislative session (Wilcox-Fogel, 2012). As it stands today, a veteran must be deemed to have had “ combat with the enemy” to be entitled to compensation for mental health conditions (Wilcox-Fogel, 2012). What constitutes “ combat with the enemy” is extremely vague, making it difficult for some veterans suffering from PTSD to have their injury recognized by the VA (Wilcox-Fogel, 2012).

The COMBAT PTSD Act would broaden the definition to include all veterans who served in a theater of combat operation during a time of war (Wilcox-Fogel, 2012). Civilian clinics and their physicians, who are responsible for treating combat stress-related injuries for the millions of veterans who receive care outside of the VA system, would benefit greatly from additional training (Wilcox-Fogel, 2012). The inclusion of cognitive behavioral therapy in treatments covered by TRICARE for veterans diagnosed with TBI would improve the affordability of crucial rehabilitative care for thousands of veterans (Wilcox-Fogel, 2012).

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