Readjustment Barriers for Post 9/11 Veterans

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READJUSTMENT BARRIERS FOR POST 9/11 COMBAT VETERANS

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Abstract

Since the Global War on Terror began in 2001, roughly two million soldiers have been deployed to Iraq and Afghanistan. All veterans returning from a theater of combat face challenges when re-integrating to American society. These challenges, however, vary greatly in severity and duration between service members. Some veterans have less severe readjustment issues that resolve without intervention, and others have more complex issues which can include physical impairments. The term "Polytrauma" is frequently used by providers when discussing soldiers with multiple impairments which can include both mental and physical health problems. These impairments, along with lack of availability of resources can create barriers to proper care for many post 9/11 combat veterans.

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Chapter One

Introduction

More than one third of U.S. soldiers have been deployed more than once, and of those, more than half have been deployed three times or more. These multiple deployments, often occurring within a year or two of the last, are unique to post 9/11 veterans. Soldiers with multiple deployments tend to have compounding issues that make each civilian reintegration more difficult than the last. Readjustment and reintegration problems usually manifest in soldiers comparatively to symptoms of depression. Many soldiers report feelings of isolation and hopelessness and a lack of self-worth when they return home. Often they will say that they feel like they have left a place and an institution where they feel valuable and needed, to a place where they are unnecessary and with which they are unfamiliar. Soldiers often feel that, even in their own home, they have lost a real understanding of their role within their family (Ehlers, Hackman & Michael 2004).

Statement of the Problems

The problems to be addressed are the many challenges experienced by soldiers returning home following a combat deployment.

Definition of Terms

Combat Deployment: Refers to the time period during which a soldier is physically placed in an area that has been designated as a combat zone by the U.S government.

Post-Deployment Mulit-Symptom Disorder (PMD): A term created to describe a disorder that involves multiple comorbid symptoms of Traumatic Brain Injury, pain, and Post-Traumatic Stress Disorder (US Department of Veteran Affairs).

Operation Iraqi Freedom: A term used to identify the US government/Iraq war. This term was used from 2003-2010. In August 2010 “Operation Iraqi Freedom was changed to “Operation New Dawn” (US Department of Veteran Affairs).

Operation Enduring Freedom: A term used to identify the US government war with Afghanistan.

Chapter Two

Review of Literature

There are special challenges for soldiers when returning home and re-defining their role within their family. During a deployment, most of which range from 12-18 months for Army soldiers, families have to adjust to compensate for the soldier's absence. For example, if a wife is deployed overseas, her husband may have to perform roles that she typically performed such as balancing the checkbook or providing daily transportation for the children. Once the wife returns from overseas, she is returning to a home that has adjusted (usually quite successfully) to her absence and she may struggle to redefine her role. Additionally, soldiers with small children often return from a deployment to find that their children have changed significantly and many times the children will be confused when the deployed parent returns to the home. These family adjustments can be some of the most difficult challenges for both soldiers and families. Veterans can face a sense of confusion and disorientation when faced with the dichotomy of being a soldier and of being a civilian.

An obstacle that many veterans face is a recently newly diagnosed condition known as Post-Deployment Multi-Symptom Disorder (PMD). This is a disorder which affects soldiers who suffer from polytrauma which often leads to Traumatic Brain Injury (TBI), Post Concussion Syndrome (PCS), and Post Traumatic Stress Disorder (PTSD), and often compound feelings of isolation and difficulty relating to others. Soldiers who return with a combination of TBI and PTSD face special difficulties with treatment because each injury compounds the other. Veteran's Administration hospitals have placed emphasis, recently, on the importance of

recognizing that treating these two conditions simultaneously produces better treatment outcomes than treating the conditions separately (US Department of Veterans Affairs).

Many veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) suffer from blast-related wounds. Injuries which occur to multiple body parts due to these blast-related wounds are termed "polytrauma" by the Veteran's Administration (US Department of Veterans Affairs). Polytrauma describes wounds that cause many physical disabilities such as amputation, hearing and vision loss, spinal cord injuries, TBI, and PTSD. Traumatic Brain Injury describes an injury that occurs when the head is hit with significant force (American Psychiatric Association, 2000). It is estimated that about one in five OIF and OEF soldiers suffer from TBI, but it is impossible to get an accurate number due to the nature of TBI. Some organizations estimate that as many as 400,000 returning troops have some degree of TBI ranging from mild (concussions) to severe (US Department of Veterans Affairs).

Polytrauma pain can be very complex and may involve multiple areas of the body, depending on the location and severity of the injury/injuries. Nerve injury can lead to many different types of neuropathic pain, and amputation can lead to phantom pain that can linger for years after the amputation. Orthopedic and soft tissue trauma can lead to nociceptive pain. Nociceptive pain occurs at the site of the injury where nerve endings called nociceptors are irritated or injured. This type of pain can be short-lived and temporary, for instance in a mild burn or bruise, or can be chronic and long-lasting if the injury is severe enough to cause severe damage to the nociceptors (Pole, 2007).

A 2003 study looking at different stressors for soldiers showed that 95% of soldiers in Iraq reported seeing dead bodies (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004). Additionally, 93% reported being shot at, 89% reported being ambushed or attacked, 86% reported receiving mortar or rocket fire, and 86% knew someone who was killed or injured in combat (Department of Veterans Affairs). These stressors alone can contribute to PTSD, however, there are additional stressors that compound the risks. Some of these stressors include multiple deployments, longer deployment times, family problems and female gender. Female soldiers face unique discrimination and attacks by Iraqi citizens and are often viewed in a more negative light than their male counterparts. Since the beginning of the wars in Iraq and Afghanistan, more than 280,000 female soldiers have been deployed to combat zones (Burelli, 2013). Additionally, female soldiers are at high risk of sexual assault from male service members. The risk is so significant that many units have set rules for the female soldiers in their command to not go out alone, not be out after dark, etc. These added stressors and restrictions raise the risk of PTSD significantly for female soldiers. Female soldiers have a higher rate of sexual abuse, and most PTSD cases arising in female OIF and OEF veterans are due to sexual abuse within the military (Middleton & Craig, 2011).

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after an individual has witnessed or experienced a traumatic event (American Psychiatric Association, 2000) Traumatic events that lead to PTSD are most often events that involve substantial risk of bodily harm or death. Post-Traumatic Stress Disorder is an increasingly common disorder affecting many soldiers returning from Afghanistan and Iraq. Recent research has focused not only on recognizing and treating PTSD, but also on its prevention. Increased attention to PTSD

has focused on the neurobiology of the disorder. Researchers have looked at how certain areas of the brain become active at the time of trauma, leading to emotional and behavioral responses, and changes in neurochemicals and hormones (Holbrook, Galarneau, Judy, Dye, Quinn & Dougherty, 2010).

Based on a growing understanding of neurobiology in PTSD, some current prevention measures include using pharmacotherapy following combat and war trauma. Combat soldiers who received morphine or ketamine following combat injury were less likely to experience subsequent PTSD compared with soldiers who did not receive these drugs as part of their treatment. Pharmacotherapy is thought to assist in the prevention of PTSD by inhibiting memory consolidation and the associated response to fear following the trauma (Holbrook et al., 2010).

Some theorists argue that memories of traumatic events are stored and recalled differently than other autobiographic memories. Traumatic events tend to be stored in memory as fragmented events (though the level of fragmentation varies) which often exclude important aspects of the event. The memories of these events are usually not in chronological order and part of PTSD treatment focuses on arranging these memories into a more organized narrative. (Ehlers et al., 2004)

Interestingly, a 2011 study found a correlation between characteristics of soldiers and posttraumatic growth. Posttraumatic growth is defined by the authors of this study as, "the positive cognitive, spiritual, emotional, and social changes that can occur after a traumatic experience." (Mitchell, 2013 p. 3) According to this study some of the characteristics of soldiers who experience posttraumatic growth include strong unit cohesion, being junior enlisted, being

married, and being a member of a minority group. This could indicate that people who are exposed to more combat may experience positive growth following trauma if they have strong social connections to others, including soldiers with whom they experience combat.

Soldiers returning from overseas are not usually treated for TBI and PTSD separately. Many soldiers are treated at a Polytrauma Rehabilitation Center or a Polytrauma Network Site. Because of the unique challenges of these problems, many veterans have a difficult time re-integrating and returning to school and work. Veteran educational and vocational benefits are encouraging more soldiers to return to school and work, and many schools and employers are unprepared to understand the needs of individuals with TBI and/or PTSD. Traumatic Brain Injury impairs an individual's ability to concentrate, think, and regulate his/her mood and emotions. Soldiers with TBI are much more likely to suffer from PTSD, particularly soldiers who reported loss of consciousness (Hill, Mobo, Hur, & Cullen, 2009). Many more soldiers from the current wars suffer from TBI and PTSD, in part because so many more soldiers are able to survive attacks thanks to advances in combat technology. Soldiers who are returning from a theater of combat are required to complete a questionnaire to screen for TBI, PTSD, and other combat-related injuries. Additionally, in 2011, the Department of Veterans Affairs began utilizing a Biograph mMR machine to screen and treat TBI. This machine works as a PET and MRI in one. This machine can help researchers understand what brain changes are associated with traumatic brain injury and PTSD in the servicemen and servicewomen coming back from Iraq and Afghanistan (US Department of Veterans Affairs).

Treatment for these conditions varies depending on the severity and duration of symptoms. An interesting new tool being utilized by the Department of Veterans Affairs is called "Virtual Iraq" (Gerati, Rothbaum, Ressler, Heekin & Rizzo, 2008). This therapy involves an affected soldier wearing a headpiece with images and sounds from Iraq. Soldiers re-experience combat events and are able to navigate through the experience at their own pace. The case study report on an individual soldier found that:

> *Short-term virtual reality exposure treatment of PTSD in an OIF veteran resulted in a substantial drop in the patient's self-reported PTSD symptoms. This participant reported feeling comfortable with the technology utilized in this form of treatment and found the treatment to be logical and credible. Although the participant still met CAPS criteria for a PTSD diagnosis at posttreatment, he anecdotally reported experiencing improvement in functioning in many areas of his life as a result of treatment, including increased ability to concentrate at work, increased communication with spouse, decreased anhedonia, and decreased avoidance of friends and fellow soldiers. He also discussed feeling that he no longer needed to "keep thinking about" the identified trauma. The limitations of an uncontrolled case report are obvious; nevertheless, this outcome provides preliminary promise for the use of virtual*

> *reality exposure therapy with OIF veterans with PTSD.* (Gereati et al., 2008, p. 5)

The array of challenges that reintegrating soldiers face can often hinder the process of returning to civilian careers, families and schools. Complex injuries vary widely between individuals who sustain trauma during deployment, and treatments must also vary to accommodate individual needs. While there are many treatment options available, and large amounts of research being conducted on these injuries, there are still many returning soldiers who are not receiving the benefits of these. Because of the large number of soldiers who return with many of these injuries, and the limited care available to some, many soldiers face the reintegration process without sufficient treatment.

Chapter Three

Conclusions and Recommendations

While many veterans do face unique challenges, they also offer skills that are very useful in an academic or employment arena. Veterans are trained to perform under extreme pressure and multi-task. Veterans are also skilled at teamwork and have experience working with a diverse group of individuals. Combat veterans have learned to adjust to changes in routine and are able to prioritize tasks based on importance. With the proper tools in place, veterans can pursue civilian education which can help them in their careers. Educational benefits are intended to work as readjustment tools for veterans. Returning to or beginning school is a positive way for post- 9/11 veterans to re-establish their roles outside of the military. It is important to recognize the value of these individuals when they re-integrate into civilian life. Extending educational and occupational opportunities are important ways of showing recognition of the veteran. They also enable the veteran to achieve, and to feel and be productive.

In addition to educational and vocational assistance, veteran's assistance programs should work toward developing better screening tools as well as providing time-efficient treatment for Post 9/11 veterans. Veterans who would benefit from the programs and benefits available through local and federal agencies should contact veteran advocacy groups in their area. Fortunately, more advocacy is available than ever before, to acquaint educational staff members and workplaces with the benefits available to returning soldiers. Federal and State GI Bills can

be used by eligible soldiers to pay up to 100% of their tuition and fees. In addition it can pay a monthly housing expense allowance and book stipend. There are also work incentives and programs for veterans. The Veterans Opportunity to Work Act of 2011 was established, in part, to improve the Transition Assistance Program that was initially established to help veterans transition into a civilian work environment. This program was a voluntary option for soldiers returning from overseas, but is now a mandatory program for soldiers transitioning into the civilian workplace. The Veterans Opportunity to Work Act of 2011 also provides tax credits for hiring veterans and disabled veterans who are out of work (US Department of Veteran Affairs).

In 2008, several campaigns were launched to assist with veteran reintegration issues. One of these campaigns is the Yellow Ribbon Reintegration Program (YRRP). This program was established for members of the Army National Guard and Reserve Service. Members of these two groups are more often unaware of potential benefits available than their counterparts in active duty army units, as reservists and national guard members often reside far from their unit base. The YRRP targets National Guard and Reservists and assists members in accessing benefits and resources that are available. These benefits can include health care, education, work/training and financial or legal benefits (Office of the Assistant Secretary of Defense for Reserve Affairs 2008). Programs like the YRRP are growing, but are still only reaching a small percentage of eligible veterans. Outreach and awareness are crucial factors for programs like YRRP to succeed.

In summary, a good share of the task of helping a veteran integrate back into civilian life is to understand and provide specialized treatment for TBI and PTSD. Though the long-term effects of TBI, in particular, are not well-understood, it is crucial for the Veterans Administration to continue to do research to improve both prevention and treatment of such injuries. The effects of these problems on reintegration, particularly reintegration into the family and community, needs further examination and effort. Assistance with accessing and using educational and vocational assistance is also of great importance to the well-being of veterans.

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