INVISIBLE WOUNDS: CLOSING THE GAPS BETWEEN MENTAL HEALTH CARE FOR VETERANS AND THE PSYCHOLOGICAL WOUNDS OF WAR

Approved by Tom Lo Gudiice
Date: May 7, 2013

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A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin-Platteville

In Partial Fulfillment of the

Requirement for the Degree

Masters of Science

in

Education and Human Services

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by

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Spring 2013

ABSTRACT

A review of literature as it relates to post traumatic stress disorder amongst service members who served in combat in Iraq and Afghanistan is presented. On June 22, 2011, the President of the United States, Barrack Obama, made an announcement 10,000 troops who are deployed in Afghanistan will be returning home by the end of 2011, with a total of 33,000 returning home by summer 2012 (Huffington Post, 2011). Thousands who served in combat are returning home with symptoms of Post- Traumatic Stress Disorder (PTSD). Due to ineffective treatment service delivery and stigma that still exists in the military, service members are left untreated. However, through the ever growing world of technology, telemedicine has emerged. Telemental health services have been utilized for a variety of mental health services and have been proven to be effective but little is known about the use of telemental health services to treat PTSD. Cognitive Behavioral Therapy, however, has been proven effective via telehealth services for treating anxiety disorders with a high level of client satisfaction. In addition to ineffective health services, the stigma surrounding mental health also needs to be addressed. The military has already developed an educational program for families. Though further research is needed, the gap in mental health service delivery amongst veterans is closing.

Key terms: PTSD, post- traumatic stress disorder, mental health for veterans, telemental health, telehealth, telemedicine, psychological wounds of war, barriers of care for veterans, stigma

ACKNOWLEDGEMENTS

There are several people who deserve acknowledgement for the development of this paper. First, and foremost, to Susan Storti, thank you for taking the time to interview with me and also for all of the editing and proofreading you did for me. I would like to thank Calvin Richardson who was very patient during the most trying times; I would not be where I am today without you. Thank you to my best friend Josh Jensen and all of my classmates and colleagues for challenging me to be the best I can be. All of the staff members at UW Platteville who were involved with my education deserve a huge acknowledgement. The amount of professionalism and attention each staff member gave both in the classroom and out is a true example of what modeling means. Their dedication to the field and the attention they all gave to me is more than I could have ever asked for. I would like to particularly thank Patricia Bromley for time and interest you have given me, not only in my growth as a student and as a counselor, but as a human being; your polish is of the highest quality.

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CHAPTER 1

INTRODUCTION

The officer approached the scene just shortly after the crew had been taken prisoner. There was blood everywhere and some of the vehicles were still smoking from the crash. Shortly after the encounter, the officer and the accompanied crew headed out and spent the next three days blasting artillery in Nasiriyah, a city in Iraq approximately 225 miles southeast of Baghdad. They traveled in a vinyl sided, non- armored vehicle while rocket propelled grenades (RPG) were flying everywhere. The vehicle took the hits endlessly, but they were not the only ones. Just ahead lay a bus that was on fire. Civilians and children were screaming, trying to get out of the bus while others were lying inside, dead. The officer got out of the vehicle, looked down, and noticed standing directly on top of a body. The body was that of an unknown soldier who had been run over and was "squished" and flattened from hands to feet by one of the vehicles. These accounts are not from scenes from a war but, rather, real life experiences shared by Chief Petty Officer and United States Navy Reservist Bob Page in his transcript *Iraq Never Leaves Us: PTSD and My Life* (n.d).

Page is now the Director of Communications for the Iraq War Veteran's Organization, Inc. (IWCO), a veteran, a father and a husband. During an online lecture, Page describes experiences while serving in the United States Marine Corps (USMC) overseas in Iraq. In August 2004, Page was demobilized and by November began experiencing symptoms of Post-Traumatic Stress Disorder (PTSD).

According to Research and Development Center for Military Health Policy Research (RAND), it is estimated that 1.64 million American soldiers have been deployed to serve in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom Afghanistan (OEF) since 2001

(Jaycox, 2008). Deployments are longer, multiple deployments are frequent, and time in between deployments is minimal. Approximately 300,000 of those deployed currently suffer from symptoms consistent with PTSD or major depression. Mental illness has begun inundating the Veteran's Administration and, subsequently, there is a growing concern amongst civilians as well as those in the military as to how the government plans on handling the crisis (Jaycox, 2008).

Purpose of the Study

The study is primarily a review of literature report. Some direct communication with professionals in the field is also reported. The purpose of the research is to identify the problems within the military's mental health treatment services. Repetitive exposure to traumatic events increases the likelihood of PTSD but stigma surrounding mental illness in the military continues to prevent soldiers from seeking help. Ignoring the symptoms and the avoidance of help will not make the symptoms disappear; untreated symptoms worsen over time. Family members and their children are also affected. Telemental health services have been utilized for a variety of mental health services and have been proven to be effective but little is known about the use of telemental health services to treat PTSD.

Significance of the Study

On June 22, 2011, the President of the United States, Barrack Obama, made an announcement 10,000 troops who are deployed in Afghanistan will be returning home by the end of 2011, with a total of 33,000 returning home by summer 2012 (Huffington Post, 2011). Those who served in combat and were exposed to traumatic events and are at high risk for the development of PTSD. Thus it is important at the federal level as a policy manner as well as for professionals that a good summary of the literature be provided.

Statement of the Problem

Due to the shortage of mental health services and the stigma surrounding mental illness in the military, how are the Veteran's Administration (VA) and public mental health facilities going to deal with the mental health crisis they are soon going to face?

Definition of Terms

The United States Department of Health and Human Services Health Resources and Services Administration (HRSA) defines telemental health as "…an integrated health care network that uses modern telecommunication and information technologies to provide comprehensive health care services to a specific group. " 'Telepsychiatry' is the specific application of telemedicine to psychiatry " (Smith & Allison, 1998, p.1).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), PTSD is an anxiety disorder characterized by a cluster of symptoms: a) physical exposure to traumatic events such as death or threat of harm on oneself or others followed by intense fearful or helpless reactions b) persistent and intrusive recollections of the event followed by psychological and physiological responses c) "persistent avoidance of stimuli associated with the trauma and [emotional] numbing…" followed by an individual's attempts to avoid thoughts, feelings, activities associated with the event and/or "inability to recall an important aspect of the trauma d) sleeping difficulties, easily agitated, "hyper vigilance, and difficulty concentrating" (APA, 2000). There are two" specifiers" of PTSD, each based on how long the symptoms persist. Acute PTSD is diagnosed when symptoms persist less than three months; chronic PTSD is diagnosed when symptoms persist longer than three months. In some cases, individuals do not begin experiencing symptoms until at least six months following the traumatic event. This may lead to a diagnosis of PTSD with delayed onset (APA, 2000).

Delimitations of Research

Research is limited to data published in professional and peer reviewed journals as reviewed using selected search engines during the summer and fall of 2012. Interviews were conducted with professionals who work directly with the National Guard in Maine and Rhode Island. Research includes reviewing transcripts of testimony by members of the Veteran's Administration as well as by veterans of OIF and OEF. The review uses popular as well as professional resources to give the reader a sampling of the lay views of the topic as well as the views of professionals. The review is not intended to be exhaustive.

CHAPTER II

REVIEW OF LITERATURE

The following information is a literature review of PTSD specific to the military population. All information was obtained from peer reviewed journals, government websites, government documents, and interviews. Information addresses problem areas within the mental health system and possible solutions for closing the gaps in delivery of services.

History of PTSD

The Executive Director of the VA Center for Post-Traumatic Stress Disorder, reported during an interview with Frontline that PTSD dates back to the Civil War (Friedman,PBS, 2005). The Director reported that after the Civil War the Soldiers who had returned home from combat were changed and their behaviors, often changed for the worse, were indicators that something was not right. Freidman said that the two models that were used to explain these behaviors were the psychological and the physiological models.

According to Friedman (PBS, 2005), 19th century Cardiologist Mendez DaCosta used the physiological model to describe cardiovascular changes Soldiers experienced such as elevated heart rates and blood pressures; the term for these physiological changes is now known as "Soldier's Heart" or "Irritable Heart." The psychological model, on the other hand, was referred to as "nostalgia" and was conceptualized by utilizing Freud's psychoanalytical theory (PBS, 2005). Traumatic neurosis, shell shock, and other terms became common labels for Soldiers' behaviors, according to Friedman. Friedman also reported that while working with World War I veterans, psychoanalyst Kardiner discovered physical and physiological symptoms such as jumpiness and sensitivity to loud noises co-occurred (PBS, 2005).

Following World War II, the psychological model was used to describe the cluster of symptoms referred to as combat stress and battle fatigue. Poet Walt Whitman, who was a nurse and a journalist during the war, described his own experiences of these unexplainable symptoms in his poem, *Old War Dreams*:

> In midnight sleep of many a face of anguish, of the look at first of the mortally wounded, (of that indescribable look,), of the dead on their backs with arms extended wide, I dream, I dream, I dream… Long have they pass'd, faces and trenches and fields, Where through the carnage I moved with a callous composure, or away from the fallen, Onward I sped at the time -- but now of their forms at night, I dream, I dream, I dream (Ritterbusch, 1992, p1).

Whitman describes a vivid, emotional sight of death and his fearful response to it. His exposure to the event caused him not only to have nightmares, but he became emotionally numb to the experience. He attempted to erase his thoughts, but they invaded his mind and he began having nightmares. His 'callous composure' describes the emotional numbing that is characteristic of PTSD.

Barriers to Care

Stigma

Stigma surrounding mental illness has a lengthy history and dates back to the 19th century when philosopher Rene Descartes developed the theory that the mind and the body were separate entities. He believed the mind was an organized region, was characterized by consciousness, could not be seen, and that its functions occurred in the brain. The body, however, was believed to be associated with illness and this "was seen as the concern of physicians" (Mental Health, n.d.) Thus, people began associating mental illness and physical illness as two separate entities

when, in fact, they actually go hand in hand. For example, a person may experience nightmares (such as Whitman) which may be followed by increased heart rate, dry mouth and sweaty palms, according to the Surgeon General. The nightmares themselves are processes that occur in the brain that provoke the physical changes that follow (Mental Health, n.d.).

Labeling individuals who were mentally ill also contributed to the development of stigma. During colonial times, the mentally ill were labeled as "lunatics" and were often cared for by their families (Mental Health, n.d.). These individuals were later placed in asylums which were eventually labeled mental hospitals. Patients suffered abuse by caretakers in these institutions which triggered a need for reform to improve treatment and to end abuse. In the 1950's, the deinstitutionalization movement attempted to achieve this, however mental illness was misunderstood and efforts to educate the public failed.

These misunderstandings have lent themselves into the military's perceptions of mental illness. Friedman believes that stigma is a societal issue; however, the Director states it is more pronounced in the military (PBS, 2005). In 2004, *The New England Journal of Medicine* published an unprecedented and landmark study conducted by Hoge and colleagues. Hoge, et al. reported that the findings, many which were based on self-report surveys, indicated that only a small portion of soldiers and Marines that were found to have a need for mental health services actually received them. These findings also suggested that military members who resist seeking treatment are concerned they will be stigmatized, considered weak, or fearful their jobs will negatively be impacted. In addition, "concern about stigma was disproportionately greatest among those most in need of help from mental health services (Hoge, et al., 2004).

The State of New Jersey Governor's Council on Mental Health Stigma quoted the Substance Abuse and Mental Health Association in regards to the ramifications of military personnel reporting mental illness:

> The impact of military reality on individual mental health is complicated further by the pronounced stigma associated with mental illness within military communities. Service members frequently cite fear of personal embarrassment, fear of disappointing comrades, fear of losing the opportunity for career advancement, and fear of dishonorable discharge as motivations to hide the symptoms of mental illness from colleagues, friends and family. This silence and the attitudes and perceptions perpetuating it pose a significant challenge to those charged with making sure that the United States' fighting force is improving itself and taking care of its own members (Military and Veterans Affairs, n.d.).

Representative Davis from Virginia stated during the Oversight Committee hearing that "…one of the steepest barriers to diagnosis and treatment of combat trauma injuries appears to be psychological. The stigma of being labeled a head case in the military culture prevents many from seeking help. It allows unenlightened officers to ignore the problem, threaten exposure as a malingerer, or counsel the sick to simply gut it out and drive on like good soldiers" (United States Congress, 2007, p 9-10).

Ineffective Behavioral Health Care System

One of the primary challenges military members have faced in obtaining behavioral health services during this conflict is obtaining effective services. In May 2007, the House of Representative Oversight Committee held a hearing in regards to the issue of PTSD and other mental illnesses that soldiers returning from combat are experiencing. One of the witnesses at this hearing, Specialist T. Smith, testified that he injured his back during training in August

2004. From 2004 until 2006, he attempted to obtain medical treatment but was unsuccessful. As a result of his injury being untreated, he received a non-deployable status; however, he was deployed in 2005, making it his second deployment to Iraq. Once he was redeployed back to the United States, he was counseled briefly. He was informed that he may begin experiencing some "adverse reactions to the war such as nightmares, [and] flashbacks…;" but they would subside and were common reactions to traumatic exposure (United States Congress, 2007).

By September 2006, Smith stated that he did experience these symptoms in addition to feelings of anxiety and elevated levels of anger, none of which seemed to dissipate. He contacted Army One Hotline for assistance. According to Smith's testimony, he was referred to a psychologist and was diagnosed with PTSD, anxiety disorder and depression. He engaged in treatment for the next few months and proceeded to inform his chain of command that he was receiving treatment.

In January 2007, only three months after his initial diagnosis, Smith was deployed to the National Training Center where he did not receive any treatment for one month but was still experiencing sensitivity to external stimuli (United States Congress, 2007).

He was then redeployed to Fort Benning where he immediately made an appointment with his psychologist who then referred him to Martin Army Hospital; his psychologist also wrote a letter of concern which Smith forwarded to his chain of command. The psychologist at Fort Benning also diagnosed Smith with PTSD, recommended he not be allowed to handle weapons, and that he should not be redeployed to Iraq so he could continue with treatment and further observation. The psychologist also wrote a letter of his concerns which was forwarded to his company commander who proceeded to brief the colonel. According to Smith, in March 2007, only hours before his redeployment to Iraq, he was informed he would need to have his

bags packed by that evening and that he was going back to Iraq. He contacted his psychologist and was sent to inpatient treatment (United States Congress, 2007).

Later in Smith's testimony, he stated he was redeployed to Iraq regardless of the fact that he was deemed unfit for combat. Smith also stated he was never offered any type of discharge. He had informed his doctor he would rather commit suicide than reengage in the combat experiences he did during his prior two deployments to Iraq. He explicitly explained that he was not mentally prepared to go through any more experiences such as those he already had (United States Congress, 2007).

When asked if Smith had known others who had been redeployed, he testified to knowing several other comrades who had been redeployed and that he even knew of some who were being redeployed as a result of the investigation for which he was testifying against. Smith offered his opinion as a Soldier and said, "nobody wants anybody with a mental condition or a physical condition trying to fight on the front lines with them" (United States Congress, 2007).

During the hearing, testimonies were given by experts regarding multiple deployments and less time at home in between deployments; according to Hoge, et al. (2004), there is a direct correlation between mental illness, length of deployment, multiple deployments, and the extent of traumatic exposure.

Education

There are many reasons that stigma surrounding mental illness still exists, the primary reason being that mental illness is misunderstood, according to the Surgeon General (Mental Health, n.d.). Society tends to associate mental illness and mental disorders with violent behavior. However, individuals with a primary mental illness are at low risk of harming someone else. In fact, the Surgeon General reports that individuals with co-occurring disorders such as

mental illness and substance abuse are more likely to become violent than those diagnosed with only one illness. In addition, the risk of someone with a mental illness harming a stranger is very low. Family members are more likely to be victims of violence and most likely to occur when the individual is seriously ill and fail to comply with his or her medication regime. During a recent interview, with Susan Storti, PhD, Director of the Addiction Technology Transfer Center of New England, Research Associate at Brown University School of Medicine, and Professor at Roger Williams Medical Center's Nursing Center for Practice and Education, stated that "public awareness and education are the best tools we have available" (personal communication, February 6, 2009). In an effort to reduce stigma, the Army now offers a variety of educational videos for children and families that assist them in developing an understanding of what military members experience while in combat as well as how to cope with problems that may surface once they return home (Hames, 2008).

Adler, senior research psychologist for Walter Reed Army Institute of Research's United States Army Medical Research Unit in Heidelberg, Germany, stated that symptoms of mental illness due to combat exposure begin to develop at different stages and that prolonged exposure along with the higher the level of combat exposure, the greater the risk of developing symptoms of mental illness, including PTSD (Huseman, 2008). The Army has developed an intervention program called *Battlemind* to assist in addressing these challenges. Based on surveys and soldiers' reported personal experiences, *Battlemind* provides education to service members during each phase of deployment. For example, prior to deployment, soldiers are briefed on "what they are likely to see, to hear, to think and to feel…by describing the worst-case scenario" (Huseman, 2008). Post deployment education also includes informing soldiers and family members of signs and symptoms to be aware of so, when something is wrong, they know when

to seek help. A second product, *Battlemind II*, was developed to address issues specific to those that occur three to six months post-deployment (Huseman, 2008).

In addition to dispelling myths regarding mental illness and educating family members about combat experiences, educating primary health care providers is a necessity, given that many military members experiencing transitional issues choose to access community based services instead of services offered through the VA. (Storti, personal communication, February 6, 2009). "Education is imperative given the experiences of our returning military. Many providers have not had the opportunity to care for individuals who are in the military and have experienced combat trauma." Service members are exposed to repeated traumatic events; the longer the deployment, the higher the likelihood of repeated exposures. "They do not have the opportunity to process the events and tend to shut down their emotions" as a means of coping with their thoughts and feelings (Storti, personal communication, February 6, 2009). Primary health care providers are often not trained nor equipped to treat this type of trauma, unlike providers in the VA who treat thousands of veterans. She also stated that community providers must understand their limitations of service and "need to recognize where their expertise ends" (Storti, personal communication, February 6, 2009).

Finally, "children of U. S. military service personnel may be some of the most vulnerable and often overlooked casualties of the Global War on Terror" (Mid Atlantic ATTC &Virginia Department of Veterans Service, 2008). Some of the short term effects are beginning to surface in the form of behavioral problems in school (Storti, personal communication, 2009). If these behavioral problems are not addressed appropriately, the long term effects could be devastating. During her recent interview, Storti, who is also a consultant for the Mid Atlantic Addiction Technology and Transfer Center (Mid Atlantic ATTC) and member of the *Virginia is for Heroes*

conference planning committee, discussed educating faculty members on the effects of combat trauma on children and other family members. The conference report suggests that educators be trained in recognizing warning signs and in understanding "the effects of parental deployment" (Mid Atlantic ATTC &Virginia Department of Veterans Service, 2008). When a child begins acting out in the classroom, rather than assuming the child is a disruption, educators should begin asking questions such as, "Is your parent in the military?" or "Do you have a parent that is home from serving in Iraq?" In doing this, she explained, educators can identify problems immediately and then make appropriate referrals (Storti, personal communication, 2009).

Combat Support Teams

Storti stated that the military has implemented Mental Health Advisory Teams which have shown to be effective in reducing some of the stigma that surrounds mental illness in the military. Carmichael wrote that Major Brett Schneider, Chief of Telepsychiatry at Walter Reed Army Medical Center in Washington D.C. led a team of 20 counselors in Iraq from August 2003 to February 2004 in an initiative designed to assist in combating combat stress trauma. During this period, Schneider and the team met with soldiers who had experienced trauma exposure ranging from "the bombing of the United Nations Building to their own experiences in combat" (Carmichael, 2005). Schneider reported that while he was in Iraq, the ridicule of seeking counseling was not apparent; his belief is that the presence of combat support teams was a contributing factor.

Carmichael (2005) wrote that combat support teams "set up camps for extended periods, basically creating a mental health clinic from scratch." There are approximately six to eight teams in theater and are comprised of psychiatrists, psychologists, nurses, counselors, and occupational therapists that travel to even the most hazardous areas. Soldiers can go to the

"psychological first aid tents" and rest for three to four days and are provided hot meals and, if necessary, sleep medication to help them rest and to provide an opportunity for soldiers to "normalize." During this time, team members will identify soldiers with psychiatric problems and can provide them with the help that they need. In some instances, soldiers may be removed from the combat zone.

Effective Treatment

One reason for ineffective treatment delivery is due to the demobilization process (Storti, personal communication, February 6, 2009). When a unit is redeployed, veterans return to the United States, but do not return home until they are debriefed, which can last up to five days. During this time, service members are questioned as to whether or not they are having any difficulties. If they do report any problems, they do not return home and remain at the base they returned to until they are seen by a mental health provider. Many times, veterans do not report any problems because they want to return to their families and make a decision to use their coping skills while in theater and deal with their problems when they return home (Storti, personal communication, February 6, 2009).

On March 10, 2005, Dr. W. Winkenwerder, Jr., of the Assistant Secretary of Defense issued a memorandum to Assistant Secretaries of the Army, Navy, and Air Force regarding Post Deployment Health Re-Assessments (PDHRA) (personal communication, March 10, 2005). The memorandum was written in response to field study results that revealed medical concerns, primarily mental health, were arising several months after redeployment. In an effort to identify and treat these mental health concerns in a more timely and effective manner, he ordered an extension of the already existent Post-Deployment Assessments (PDHA). Winkenwerder stated "the post-deployment health assessment will be conducted for all personnel from 90 to 180 days

after return to home station from a deployment that required completion of a post-deployment health assessment" (personal communication, March 10, 2005).

Pulitzer Prize winning journalist Newhouse discussed the effectiveness of periodic screenings and assessments as a tool for identifying early warning signs of PTSD and other mental illnesses in his book *Faces of combat, PTSD and TBI: One journalist's crusade to improve treatment for our veterans* (2008). The Montana National Guard was selected to conduct a national pilot study to include a second PDHRA two years after the initial PDHRA is conducted. The purpose of this study was to determine efficacy of the second PDHRA in the early detection of PTSD or other combat related disorders. The study revealed that symptoms of PTSD were surfacing 18-24 months after re deployment, nearly all cases of which were a direct result of an earlier deployment (Newhouse, 2008). Based on these findings, the Department of Defense (DOD) authorized an extension and provided funding to the state of Montana allowing them to conduct periodic assessments every six months for up to two years after redeployment. The purpose of this study was not only to assist in the detection of symptoms more efficiently, but to assist in the referral of services in a more timely fashion (Newhouse, 2008).

Storti (2009) stated that Rhode Island has also initiated a program in dealing with the problems of combat related mental illness and treatment delivery. Each state has similar demobilization procedures, but Rhode Island has stations that are set up, one of which is a VA/Vet Center where all services are available. Every member has access to the VA registration process and, at the same time, has an opportunity to speak with a provider. These providers include psychiatrists, licensed social workers, vet center members, and OEF/OIF outreach program members. When service members leave the station, they have a card with all of their registration information on it. 30, 60, or 90 days later, if the individual wants to access VA

services, their information is already registered with the VA, making the process more efficient (Storti, personal communication, 2009).

Once veterans have requested mental health services, a question is raised as to the most effective form of treatment to provide. In June 2004, the National Center for PTSD developed the *Iraqi War Clinician Guide* which discusses Cognitive Restructuring, a form of Cognitive Behavioral Therapy (CBT), as a valid and effective method for treating combat related PTSD. The National Association of Cognitive Behavioral Therapists (NACBT) reports that Cognitive Behavioral Therapy (CBT) "is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do" (Cognitive Behavioral Therapy, n.d.) It is based on the theory that there is a causal relationship between thoughts, feelings and behavior. In addition, situations or events are not the cause of an individual's behavior, but rather, it is a person's thoughts that evoke certain feelings and emotions and it is those thoughts and feelings that lead to his or her behavior (Cognitive Behavioral Therapy, n.d.). CBT is not a specific form of therapy but, rather, a broad classification that encompasses a variety of approaches, including Exposure Therapy. Foa et al. reported that exposure therapy is one of the most widely used methods of treating PTSD. During this method of treatment, individuals are "…exposed to their own individualized fear stimuli repetitively, until fear responses are consistently diminished" (as cited in Department of Veterans Affairs National Center for PTSD, 2004).

Newhouse writes that with PTSD, "[CBT] operates in the theory that trauma is secondary to the perception of trauma" (2008, p.224). Individuals perceive things differently and, therefore, when they are faced with situations, their reactions are different and their behaviors will be based on those perceptions. He adds, "[CBT]…involves thinking about the way you act and trying to

lessen learned responses to certain situations. By removing the thinking patterns that are wrong in a civilian world, the theory is that we can also change our behavior" (Newhouse, 2008, p.224).

Telemental Health

At the American Psychological Association's (APA)'s 161st annual meeting held at the Washington Conference Center on May 6, 2008, Col. Elspeth C. Ritchie, psychiatry consultant to the Army's surgeon general and Director of the Proponency for Behavioral Health, discussed the use of telemedicine as a means of delivering behavioral health services to service members and veterans. Telemedicine was introduced in the 1920's in Norway to provide health care support via radio links to ships at sea. Approximately 30 years later, Dr. Cecil Watson of the Nebraska Psychiatric Institute expanded this concept by providing education and instruction to behavioral health students at the Medical College of Nebraska. As technology advanced during the following three decades, the National Institute of Mental Health funded several telemental health research projects which have led to more advanced audiovisual treatment capabilities. Baer, Coker and Coyle reported interviewing children, adolescents, and patients with schizophrenia was more effective utilizing telecommunications than it was with actual face to face contact (as cited in Smith & Allison, 1998, p 4) "…The technology was said to be more effective with these groups than the established 'best practice'" (Smith & Allison, 1998, p 4). For example, physical and emotional responses may be observed without invading the patient's personal space. By confronting a patient's destructive behaviors and abuse, the separation between the patient and the therapist "creates a comfort zone" that is established for further work (Smith & Allison, 1998, p 4).

According to the Department of Veterans Affairs National Center for PTSD, individuals who suffer from PTSD often isolate themselves by relocating to remote, rural, and densely

populated regions (Morland, et al., 2011). It is in these rural and remote areas individuals who are in need of behavioral health services do not receive them due to financial, transportation, or personnel burdens. “Telemedicine, and in particular, telemental health networks, have the potential to diminish the disparity of mental health care based on population density characteristics” (Smith & Allison, 1998, p 12). Ritchie stated that web based videoconferencing allows soldiers to meet with therapists individually; phone consultations are also available although, due to connectivity problems, web conferencing is more reliable. Because behavioral health services do not require physical contact, a wide range of services can be offered utilizing telemental health technologies. Some of these services include screening, assessments, treatment planning, case management, medication management, psychotherapy, and family group sessions (Smith and Allison, 1998, p 12).

In an effort to update a previous literature review of telepsychiatry, Monnier, Knapp and Frueh (2003) identified sixty eight peer reviewed publications dating from 2000 to 2003. Their findings included current program descriptions, reliability of clinical assessments, clinical outcomes, satisfaction of clinicians and patients, cost effectiveness, and legal and ethical issues (2003). Studies of eight adult patients diagnosed with panic disorder with agoraphobia, CBT was delivered via telepsychiatry; in all cases, patients reported a decrease in symptoms of anxiety and an overall improvement in their functioning. In studies of adolescents diagnosed with oppositional defiant disorder and attention deficit disorder, telepsychiatry was utilized for medication management, individual therapy and family therapy, the result being an improvement in behavior. Other populations studied were the elderly, incarcerated adults, and veterans. In these cases, telemental health led to patient satisfaction due to the increase in accessibility to services. In addition, according to Monnier, Knapp, and Frueh, telemental health services are

also being introduced on a larger scale and are being implemented in Southern Australia, Finland, the United States Military's National Naval Medical Center, and the University of California, Davis, and the Medical College of Georgia (2003).

Clinical assessments have been conducted through the use of videoconferencing amongst a variety of populations including the elderly, medically ill veterans, and in child psychiatry; literature suggests that telepsychiatry service delivery was an adequate alternative to face to face assessments for depression and cognitive status (Monnier, Knapp, & Frueh, 2003). Further studies may be needed, however, to address specific populations when utilizing more standardized assessments.

Client satisfaction was the predominant theme in regards to the delivery and effectiveness of telemental health. Although some studies found some professionals had a negative perception and believed communication was ineffective and disrupted the therapeutic process, overall, patients were highly satisfied with receiving their mental health services via teleconferencing. One thing the research was unable to identify was whether or not patients would prefer face to face contact rather than through the use of telepsychiatry. Most patients described videoconferencing as a means of receiving mental health services as "'almost as good'" or "'as good'" (Monnier, Knapp, & Frueh, 2003). Telephone surveys in rural Midwest showed found that "two thirds of respondents were willing to participate in psychiatric treatment delivered via teleconferencing equipment" (Monnier, Knapp, & Frueh, 2003).

Finally, according to Monnier, Knapp and Frueh (2003), there is minimal research providing any substantial information in regards to the ethical implications of telemental health service delivery. Some questions that were raised were found in their review of McCarty's *Telehealth Implications for Social Work Practice*. McCarty recorded concerns including

licensing and regulations pertaining to providing services across state lines, liability and malpractice issues and privacy and confidentiality issues, particularly in regards to informed consent. In Monnier, Knapp and Frueh's (2003) review of Capner's *Videoconferencing in the Provision of Psychological Services at a Distance,* concerns were also raised in regards to professional licensing in addition to liabilities for harm to clients, which site is considered the treatment site, the point in which the therapeutic relationship is established, and an increased likelihood that clinicians would be charged with malpractice due to unacceptable standards of care. However, Capner suggested that "failure to obtain a consultation may soon be deemed a violation of the 'standard of care' as such a consultation would be readily available using telemedicine technology" (Monnier, Knapp, & Frueh, 2003).

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

PTSD has existed since before the Civil War but, unfortunately, little was known about it. There is now sufficient evidence that those who serve in combat are exposed to traumatic events that can change their lives forever. Left untreated, symptoms persist and often worsen. Military personnel have been trained to be strong and to fight for their country. A vast majority of those who suffer from symptoms of PTSD and other mental illnesses are afraid to step forward for fear they will be chastised, viewed as weak, or that their jobs will be jeopardized. Descartes' theory that the mind and the body are two separate entities is a fallacy that has created negativity in the mind of society. The military's negative perception of these illnesses is even more exaggerated. Service members serving in Iraq fight for their country every day and are exposed to violence, death, fear, pain, and bloodshed that haunt them when they return home, yet they are not provided with adequate care. In addition to the lack of care they receive, they are forced to redeploy with limited time in between to be with their families. All of these factors place military members serving in Iraq at high risk for developing symptoms of PTSD and other mental illnesses.

The mental health epidemic that is sweeping across the United States' armed forces as a result of OIF is one that needs to be addressed, not only while in theater, but periodically over time. Studies have shown that symptoms of PTSD often do not surface until six months to a year after exposure to trauma. It has taken this country nearly forty years to begin gaining a real understanding for the causes of PTSD and other mental illnesses war veterans suffer. Whether it

is named shell shock, Soldier's Heart, or PTSD, the dreams, the nightmares, the racing pulses, the impulsive, anxious, and sometimes violent behaviors are all too familiar. The loss of sleep, hyper vigilance, and recurring thoughts are nothing new. These symptoms and behaviors are experienced by thousands and thousands of veterans who are returning home from the war in Iraq.

Unfortunately, there are no easy solutions to either of these problems. Just as mental illness was a new concept back in the Civil War, the effects of ground war combat on an individual's psyche is also a new concept. It would be easy to say the simplest answer would be to end the war and for all of the troops to return home. It would seem simple enough to hire more counselors, provide more extensive screenings and stop deploying troops altogether. To some, it may make sense to provide more counseling and prescribe medications to ease the symptoms. However, doing any of these things would only create more problems that could potentially exacerbate the already existing ones. For example, if all the troops returned home now, the medical health system would not be able to care for all of them and they would continue receiving inadequate care, if they were able to receive any care at all.

Through the use of interactive television and other technologies, behavioral health providers have the capabilities of providing their services to underserved regions without having to physically meet face to face (Smith & Allison, 1998). "Telemental health services are bridging the health services access gap not only for those who traditionally have had limited access to mental health services, in particular those in rural and frontier areas, but also for those who because of mobility problems, poverty, or incarceration have limited access to health care services" (Smith & Allison, 1998). For example, mental health services were nearly nonexistent at Fort McCoy, an Army National Guard base in Wisconsin. Due to its rural location and lack of

funding, it was difficult to recruit enough staff to adequately run mental health programs. There were few psychiatrists that resided in the surrounding area and, if they were recruited, it was difficult to keep them there because they did not want to live there. Due to the lack of services available, veterans and service members had to take a bus to Fort Knox, Kentucky, which is 600 miles from Fort McCoy. Through the use of telemental health services, however, service members were able to remain at Fort McCoy and teleconference with staff at Walter Reed while viewing a television monitor, all of which was done real time (Carmichael, 2005).

In the July 2008 issue of *Behavioral Health*, D. Edwards, Editor in Chief, reported that the VA served approximately 22,578 veterans through the use of telehealth services from October 2007 through May 2008. This was made possible by the linkage of VA providers by civilian providers who hosted telemental health equipment. Carmichael (2005) reported that approximately 250 veterans are served per month via telemental health technology at Walter Reed. Some of the veterans' initial concerns were that they wouldn't be able to express their feelings effectively without having personal face to face contact. However, after one session, most discovered this was not true and were open and receptive to it. According to Smith and Allison (1998), "participant satisfaction surveys reveal that consumers perceive telemental health services as worthwhile, of high quality, and worth continuing."

Recommendations

Although there have been vast studies proving that telemental health is an effective way for providing mental health services, minimal studies have been conducted as to its effectiveness in treating PTSD (Smith & Allison, 1998). In 1998, Smith and Allison indicated more funding was needed for rigorous research studies; today, this is still the case. Further research is necessary to examine outcomes on a variety of levels. Confounding factors such as previous

trauma exposure, length of time in combat, length of exposure, length of time in between deployments, type of exposure, gender varying responses to trauma, support, branch of military, and the individual's personal belief systems will need to be taken into consideration. Due to the length of time it takes for symptoms of PTSD to surface, and due to the length of time the symptoms continue, it will be necessary for longitudal studies to be conducted, meaning it could take several more years before outcome measures are reported. In the meantime, the research that has been conducted has led to evidenced based telemental health treatment practices in almost every scope of mental health services. Studying the effectiveness of telemental health for treatment of PTSD specifically with individuals who served in combat in OIF and OEF is paramount. Since combat support teams are already utilized in theater, it would only make sense to parallel telemental health studies with the face to face psychiatric care already being provided to service members during their in theater resting periods. By treating symptoms sooner than later, it is likely a decrease in the severity of those symptoms would be achieved. CBT has already been found to be an effective modality for treating anxiety disorders and other combat related mental illnesses via teleconferencing. Broadening research to include CBT methodologies such as exposure therapy via teleconferencing could mean the elimination of a broad range of societal issues resulting from individuals with PTSD not being treated.

Ineffective treatment service delivery is not the sole responsibility of service members and clinicians. Throughout history mental illness has been stigmatized by society and the military. For this reason, military members have viewed seeking help as a sign of weakness. In the case of Sgt. Smith, the psychiatrist made recommendations that were ignored by the military. Education about mental illness has been proven to be an effective means of reducing stigma and should be incorporated into service member basic training. It should also be a requirement for

supervisors to adhere to the recommendations of mental health professionals. Protecting service members should be made as much of a priority by the government as it is for the government to protect the country.

It is unknown what the counseling field is going to face once soldiers return home from OIF and OEF. History repeats itself, however, and research has already proven service members are going to face a barrage of mental health problems. With the guidance of ever growing technology and more effective treatment delivery approaches, the gap that exists in the military's behavioral health system will be closed and the invisible wounds known as combat related mental illness will no longer be transparent.

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