

Texas Behavioral Health Institute
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Combat Stress and Substance Abuse: Understanding the Challenges Experienced by Returning Military Members and Their Families

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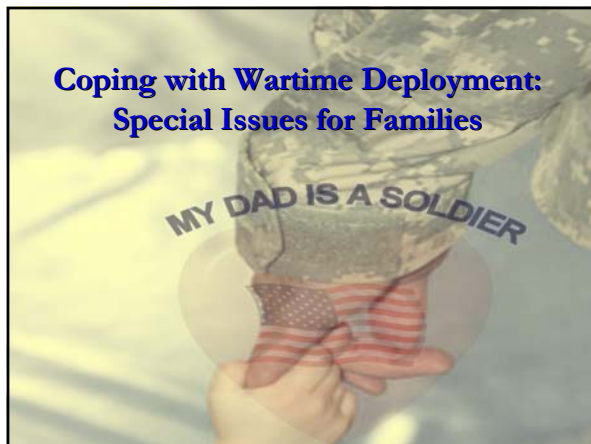


National Demographics

- Over 2.2 million U.S. Forces have deployed to Iraq and Afghanistan
 - 49% Former Active Duty (85% male; 15% female)
 - 51% Reserve and National Guard (82% male; 18% female)
- 52% is between 18 and 24
- 24% between 25 and 30
- 51% of military members are married and 45% have children
- Up to 75% of the fighting force have been deployed more than once



Coping with Wartime Deployment: Special Issues for Families



Emotional Cycle of Deployment

- Initial intense fear and worry
- Detachment and withdrawal as deployment nears
- Loneliness and sadness soon after military member leaves
- Adjustment period
- Reunion
- Effect of pre-existing difficulties

Coping With Fear of Unknown

- Limited communication with deployed
- Impact of media
- Internet
- Need to maintain realistic perspective

Changes in Family Structure

- Expanded definition of family
- Changes in family structure
- Younger families may choose to move to be near their parents
- Spouse at home faced with managing unfamiliar tasks
- Impact of mothers being deployed
- Every service member and their family are affected in some way
- Families that are flexible regarding roles and responsibilities better able to adapt

How Deployment Effects on Children and Families

Children's reaction vary developmental stage, age, and preexisting psychological or behavioral problems.

- Young children: separation anxiety, temper tantrums, changes in eating habits
- School-age children: decline in academic performance, mood changes, physical complaints
- Adolescents: anger, act-out, withdraw, show signs of apathy

American Psychological Association Task Force on Military Deployment Services for Youth, Families and Service Members (February 2007). *The psychological needs of US military service members and their families: A preliminary report*. Washington, DC: American Psychological Association.

How Deployment Effects on Children and Families

Mansfield et al. (2010) – examined outpatient medical records from 2003-2006 of over 250,600 wives of active-duty U.S. Army soldiers and compared mental health diagnoses according to the number of months of deployment Iraq and Afghanistan

Findings:

- Spouses of deployed soldiers receive significantly more mental health diagnoses
- Most common diagnoses: depression, sleep disorders, anxiety, acute stress reaction and adjustment disorder
- More likely to have more than one condition
- Prolonged deployment associated with more mental health diagnoses

Mansfield, A. J., Kaufman, J. S., Marshall, S. W. et al. (2010). Deployment and the use of mental health services among US Army wives. *New England Journal of Medicine*, 362(2), 101-109.

Homecoming After Deployment



What Is Normal Reintegration?

- Limited scientific research
- Time varies from one individual to another
- Behaviors and emotions vary from one individual to another
- There is no set process for reintegration

Post-Deployment Readjustment

*“Normal” Reactions
to
“Abnormal” Events*

Major Stressors While In Theater

- Separation from family/friends
- Concerns about home
- Difficult living/working conditions (poor food, lack of privacy, climate, extreme physical exertion, etc.)
- Multiple demands, long hours

Major Stressors While In Theater

Daily Life...

- Periods of intense violence followed by inactivity
- Need to maintain an unprecedented degree of vigilance
- Rules of engagement change often
- Sleep deprivation



Major Stressors While In Theater

- Witnessing human suffering (poverty, close friends seriously injured/killed, etc.)
- Witnessing the aftermath of war (death – enemy and civilians, destruction, dead and mutilated bodies, horrific injuries, devastated homes, communities, handling human remains, etc.)
- Constant threat of death/injury (mortar attacks, IEDs, suicide bombers, urban warfare, etc.)

It's a long way home!



Major Stressors While In Theater

- Combat exposure, including: being shot at, firing own weapon, etc.
- Sexual trauma
- Every day decisions/behaviors take on a life and death significance
- Struggle over what Service members “know” about right and wrong and what they must do to survive –
-- inflicting injury and death (enemy, civilians, friendly fire)

What are “Normal” Reactions to these types of experiences?

- The “fight, flight or freeze” survival response is a biological adaptation to war zone threats
- It is “normal” to experience the “fight, flight, or freeze” response when under threat but it can carry over to civilian life, leading to hyperarousal (jumpy, poor sleep, difficulty concentrating)

Survival Stress Reaction

Fight, Flight, Freeze (Massive release of stress hormones)

- Increase HR and blood pressure
- Blood sugar increases
- Increased blood clotting
- Tunnel vision
- Event recorded in “high definition”
- Increased cholesterol
- Pain sensation dulled – natural morphine (endorphins)
- Increased alertness, increased focus
- Memory loss from parts of the event
- Increased strength, energy, aggression
- Hearing may shut down
- Time slows down or speeds up

What are the “Normal” Reactions to these Experiences?

Physical	Thinking/Emotional	Behavior/Emotional
Headache	Questions one's performance	Withdrawal
Tremors	Nightmares	Antisocial acts
Chills	Suspicious	Fear
Fatigue	Intrusive thoughts, images	Guilt
Nausea/vomiting	Decreased memory/concentration	Grief
Thirst	Blaming someone	Panic
Shortness of breath	Poor attention	Anxiety
Visual difficulties	Disorientation	Irritability
	Feel powerless in controlling emotion	Emotional outbursts
	Miss the adrenaline rush/want to return	Inability to rest
		Hyper alert
		Increased AOD use
		Avoid crowds

Post Battle Debriefing

Reintegration

- Happiest day of a soldier's life
- Feelings of detachment, not belonging, the world went on without them.
- The soldier tries to use the same skills that they used in a combat situation to cope with adjustment
- Large variability between the National Guard/Reserve Component and Active Duty Component

Returning Home Stressors for Military Members

- A lot has changed since deployment
- Feels a bit out of place
- NG and Reserves lack the interaction with other soldiers experienced by active duty units “feel all alone”
- Less support for single military members
- Civilian life mundane and insignificant when compared to combat
- Americans seem not interested or concerned about the military members in Iraq and Afghanistan
- “Did you kill someone over there?” “Did you get shot at?” “Why did you go?”
- What to do with all the free time

Family Reintegration

- Roles have shifted and have been reestablished
- Couples have learned to live apart and independent and a new relationship needs to be explored
- Losing developmental stages of a child's life
- Not knowing when to "jump in" with child discipline
- Split feeling of being overwhelmed with the responsibility of the family and bored with the mundane part of life
- Life becomes more hectic

Returning Home Stressors for Family Members

- A lot has changed since deployment
- Doesn't understand why things can't be the "way they were"
- Family members may feel all alone in trying to assist loved one
- Life becomes more hectic
- Family members, especially children may feel emotionally disconnected
- Some male partners experience resentment or misunderstanding towards their returning woman veteran.
- Parents face similar stressors
- Triggers

Society Reintegration

- Simple tasks seem difficult
- Driving is not comfortable and often reckless
- Being irritable over small issues
- Not being comfortable around people
- Denial about the fact that they have changed as a person

Other Considerations That May Impact Family Reintegration

- Military member suffered a loss of limb or is seriously wounded
- Traumatic brain injury
- Other medical conditions – loss of hearing; orthopedic injuries, cardiovascular, gastrointestinal, and musculoskeletal disorders
- Possible exposure to both sexual assault and combat trauma

Special Concerns for National Guard and Reservists

- Financial hardship
- Absence of consistent community
- Effect of prolonged deployments
- Suddenly military
- Feelings of isolation
- Employment
- Healthcare
- Stigma

Women Veterans and Family

Family issues are paramount

- Often in caregiver role
- Partner conflict
- Parenting skills
- Domestic violence
- Young children
- Divorce

Response to Stress

- Many early symptoms resolve without intervention within the first few months of being home
- Everyone experiences a flood of stress hormones in response to trauma. These hormones prime the body for the fight or flight response as well as increase heart rate, constrict blood vessels, and provide a surge of adrenaline for energy.
- In approximately 25% of people, these hormones remain elevated for hours, days, and sometimes weeks after a traumatic experience. These individuals are at risk for developing PTSD. The longer the adrenaline surge lasts, the more vivid the memories become.

Intrusive Symptomatology	Avoidant Symptomatology	Hyper Arousal Symptomatology
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Flashbacks	Amnesia of the event	Hypervigilance
Intrusive memories of event	Avoiding thoughts and reminder of the trauma	Decreased sleep
Nightmares	Diminished interest	Decreased concentration
Increase stress response with reminders of trauma	Feeling cut off from the others	Increased startle response
	Emotionally numb	Irritability



How Are Our Veterans Coping?

Common Drugs of Abuse

- Alcohol
- Narcotics (morphine, heroin)
- Benzodiazepines
- Marijuana
- Stimulants (cocaine, methamphetamine)
- Steroids

SPICE

(Also known as “Funky Green Stuff,” “Black Magic Smoke,” “K2,” “Blaze,” and “Red X Dawn”)



Effects of Substance Abuse and Dependence

- | | |
|---|---|
| <ul style="list-style-type: none"> ■ Increased emotional withdrawal and numbing ■ Increased symptoms of depression ■ Increased risk of self destructive actions ■ Increased risk of violence toward others, i.e., fighting ■ Reckless high speed driving | <ul style="list-style-type: none"> ■ Use of firearms ■ Domestic violence ■ Physiologic dependence on alcohol and/or drugs ■ Trigger flashbacks ■ Increased irritability and acoustic startle ■ Loss of job, family, friends, etc. |
|---|---|

Does Alcohol Use Help or Relieve Symptoms?

- High correlation with PTSD
- May be used to improve sleep
- Blocks anxiety and panic attacks
- Stops intensive thinking and memories
- Stops terrifying nightmares
- Induces psychic numbing – making it easier to withdraw
- Survivors guilt
- Calms anger, irritability, restlessness

Millennium Cohort Study

- Examine the association of combat exposures to new-onset or continued alcohol consumption, binge drinking, and alcohol related problems.
- Sample – 77,047
 - Active Duty – 26,613
 - National Guard/Reserve – 21,868
 - 5,510 deployed with combat exposure
 - 5,661 deployed without combat exposure
 - 37,310 did not deploy

Jacobson, et al. (2008). Alcohol use and alcohol-related problems before and after military combat deployment. *JAMA*, 300(6): 663-675.

Millennium Cohort Study

- Reserve and National Guard personnel who deployed and reported combat exposures were significantly more likely to experience new-onset heavy weekly drinking, binge drinking, and alcohol-related problems compared with non-deployed personnel.
- The youngest members of the cohort were at highest risk for all alcohol-related outcomes.

Pain and Substance Use

- In 2009, nearly 3.8 million prescriptions were written for pain medications, up from 866,773 prescriptions in 2001
- Pentagon records also show that abuse of prescription drugs by the military is more than twice that seen in the civilian population --- 5% compared to 11%, according to a 2008 military survey measured against a 2007 civilian survey
 - OxyContin and Vicodin most abused painkillers
 - Out of nearly 30,000 troops, 1 in 4 admitted abusing prescription drugs, most being pain relievers, in a 1 year period
- Pain is the most commonly reported complaint of Iraq- and Afghanistan-era veterans treated by the VA

Armed Forces Health Surveillance Center, "Number of Service Members Deployed to OEF or OIF Who Were Prescribed Antidepressants by Year of Deployment Start," undated.

Diagnosed SUD Among OIF/OEF Veterans with PTSD

- 303,223 new users of VA healthcare (2001-2008)
- Most common MH diagnosis: PTSD – 24%
- Other co-morbid mental health diagnosis
 - Alcohol Use Disorder – 22%
 - Other Drug Use Disorder – 10%
 - Anxiety – 29%
 - Depression – 53%

Cohen, B.E., Marmar, C., Ren, L., et al. (2009). Association of cardiovascular risk factors with mental health diagnosis in Iraq and Afghanistan War Veterans using VA health care. *JAMA*, 302(5), 489-492.

Providing Services

A Need to Understand...

- Culture of military
- Culture of war
- Family dynamics
- Special concerns for Guard/Reserves
- Returning home stressors
- Personal views
- Stigma

A Need to Understand

Culture of the Military

- ✓ Important to ask how would they like to be referred to by title, rank or if separated Mr. or Ms.

Army = Soldier
Air Force = Airman
Navy = Sailor
Marines = Marine
Coast Guard = Guardian
Merchant Marines

Watson, P. J. (2009). PTSD 101. Retrieved February 10, 2009 at: http://www.ptsd.va.gov/professional/psd101/course-modules/military_culture.asp

A Need to Understand

Rank

Enlisted; Warrant Officers; Commissioned Officers

Specialty

MOS – Military Occupational Specialty

NEC – Navy Enlisted Classification

- ✓ Assessing rank and MOS/NEC can often provide valuable information regarding where they fall in the military structure and the special duties they may have been responsible for.

- ✓ Military Rank Chart:

www.defense.gov/specials/insignias/enlisted.html

(Watson, 2009)

Assessment

- Ask about:

- ✓ Length in service
- ✓ Deployment history
- ✓ Other adversities
- ✓ Education and treatment while on active duty
- ✓ Discharge type
- ✓ Military/Veteran identity

(Watson, 2009)

Assessing for PTSD

- Can easily be misdiagnosed and inappropriately treated
- Other conditions must be ruled out
 - Traumatic brain injury
 - Concussions
 - Delirium
 - Seizure disorders
 - Alcohol and other drug
- Gentle probing in a non-judgmental manner
- **Initial screen for alcohol/drug use and PTSD**

(Watson, 2009)

Assessing for PTSD

- Indirect questioning:
 - “Did you have any particularly intense or difficult experiences that stick with you now?”
- Third person:
 - “Were there any assignments or events that your fellow service members found really challenging or stay with you now?”

(Watson, 2009)

Primary Care Posttraumatic Stress Disorder Screen

Have you had any experience that was so frightening, horrible, or upsetting that, **in the past month**, you:

- Have had nightmares about it or thought about it when you did not want to?
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?

The PC-PTSD should be considered "positive" if a patient answers "yes" to any two items.

(US Department of Veteran Affairs' National Center for PTSD; available at: http://www.ncptsd.va.gov/nemain/ncptocs/fact_shts/fs_screen_disaster.html)

Important to Remember.....

- Patients/families experiencing PTSD may seek consultation in a variety of ways
- Although some patients will want to talk; most will have difficulty discussing what happened
- Do not press traumatized patients too soon or too intensely to discuss experience
- Begin process by concentrating on immediate needs of patient
 - symptoms that require emergency intervention
 - symptoms that are most disruptive to patient
- Refer to appropriate level of care

What Treatment Modalities Show the Best Outcomes for Treating SUD in Returning Military Members?

Addiction-Focused Pharmacotherapy

- Addiction-focused pharmacotherapy should be considered, available and offered if indicated, for all patients with opioid dependence and/or alcohol dependence.
- Addiction-focused pharmacotherapy should be provided in addition to indicated pharmacotherapy for co-existing psychiatric conditions.

Pharmacotherapy for Alcohol Dependence

- Oral naltrexone, an opioid antagonist, and acamprostate for patients with alcohol dependence.
- Medications should be offered in combination with addiction-focused counseling.
- Injectable naltrexone should be considered when medication adherence is a significant concern in treating alcohol dependence

Is Opioid Agonist Treatment Medication Appropriate for, and Acceptable to, the Patient?

Opioid agonist treatment is the first line treatment for chronic opioid dependence that meets DSM-IV-TR criteria.

Methadone

Buprenorphine

Addiction-Focused Psychosocial Interventions

- Indicate to the patient and significant others that treatment is more effective than no treatment (i.e., “Treatment works”).
- Consider the patient’s prior treatment experience and respect patient preference

Addiction-Focused Psychosocial Interventions

- Regardless of the particular psychosocial intervention chosen, use motivational interviewing style
- Emphasize retention in formal treatment **and/or** active involvement with community support for recovery.
- Use strategies demonstrated to be efficacious to promote active involvement in available mutual help programs (e.g., Alcoholics Anonymous, Narcotics Anonymous)

Psychosocial Interventions Menu of Options

- Behavioral Couples Therapy
- Cognitive Behavioral Coping Skills Training
- Community Reinforcement Approach
- Contingency Management/Motivational Incentives
- Motivational Enhancement Therapy
- Twelve-Step Facilitation

What Treatment Modalities Show the Best Outcomes for Treating PTSD in Returning Military Members?

Pharmacotherapy

- Duration of treatment usually longer for PTSD
- Larger doses and combination of medications may be needed
- Symptoms that may respond to meds:
 - anger depressed mood
 - hostility flashbacks
 - violent impulses anxiety
 - poor concentration nightmares
 - sleep disturbances

Decrease Arousal First

- Irritability
- Being tense
- Feeling unsafe (hyper-vigilance)
- Difficulty concentrating
- Exaggerated startle response

Pharmacological Treatment

Anti-Adrenergic/ Anti-adrenalin

(e.g., Inderal, Minipress, Catapres)

Benzodiazepines

(e.g., Klonopin, Xanax, Serax, Ativan, Librium, Restoril)

Atypical Antipsychotics

(e.g., Seroquel, Risperidone, Zyprexa)

Sleep medications

(e.g., Trazodone, Clonazepam, Ambien, Atarax, Vistaril)

Pharmacological Treatment

Tricyclic Antidepressants (TCAs)

(e.g., Elavil, Sinequan, Desyrel, Serzone)

Monoamine Oxidase Inhibitors (MAOIs)

(e.g., Nardil, Parnate, Marplan, Emsam)

Selective Serotonin Reuptake Inhibitors (SSRI)

(e.g., Paxil, Prozac, Celexa, Lexapro)

Anticonvulsants

(e.g., Lithium, Tegretol, Depakote, Topamax)

Psychotherapeutic Interventions

Psychotherapy Interventions

- Cognitive Behavioral Therapies
 - Prolonged Exposure Therapy
 - Stress Inoculation Training
 - Cognitive Processing Therapy
- Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse
- Acceptance and Commitment Therapy
- Dialectical Behavior Therapy
- Eye Movement Desensitization and Reprocessing
- Motivational Interviewing
- Group Therapy

Treatment Considerations

Research into mitigating PTSD suggests that certain courses of action can help military members develop resiliency and avoid the symptoms of PTSD.

These include:

- being positive and feeling like a survivor
- connecting to social and family support networks
- coping with stress without avoiding the issue
- having some spiritual belief
- seeking help and helping others
- talking about the trauma

Treatment Strategies

- Never say “I understand”, unless you are a combat vet.
- Never request or ask for specifics of the traumatic event. (vicarious re-traumatization)
- Individual work, group work when stabilized
- Partner with experienced medical/psychological professional
- Monitor physical condition as well as psychological (diet and sleep)
- Support with consistency and honesty
- Clear and direct communication
- Reasonable and measurable goals
- Support for family/significant others

When working with Vet's the situation may change from moment to moment. Organize in the moment to be responsive.

- Evaluate, size things up, suicide & depression
- Identify resources as available
- Coordinate deployment of resources
- Continue to re-assess, re-identify and re-deploy

During this process you may have to change hats.

- Advocate
- Organize with other clinicians
- Join with other concerned groups



Photography by Tyler Stahlfeld

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