The New Warrior: Combat Stress and Wellness: Provider Perspectives

Written Video Transcript

[00:01.40.00] I'm proud to introduce our program on combat stress and wellness. As secretary of veteran affairs and a Vietnam combat veteran myself I feel a personal connection with all of the men and women returning from the global war on terror. [00:02.00.00] Compared to Vietnam and prior wars there are differences in the new warriors coming home from Iraq and Afghanistan. We must understand their unique issues to give them the best possible care. We invited Senator John McCain to say a few words because he represents true resiliency. [00:02.20.00] During Vietnam Senator McCain not only survived being a prisoner of war, but then went on to become a United States senator.

I'm pleased to welcome you to this program dedicated to our new warriors who served in Operation Enduring Freedom and Operation Iraqi Freedom. [00:02.40.00] As most of you may know I served in Vietnam and was held a prisoner of war for many years. I've seen how the lives of our men and women in uniform can be profoundly affected by combat, injury, deprivation or other wartime stressors. There's a range of common stress responses and readjustment [00:03.00.00] phases. Most adopt well. Some may need assistance. All of us in Congress, the DOD, VA, families and communities share a responsibility to encourage and support their resiliency and post-deployment readjustment into society. Our military [00:03.20.00] men and women have answered the call. Now we have the responsibility and the privilege to answer the call from them; the call for understanding, support, patience and expert clinical care.
[00:03.40.00] [00:04.00.00]
I just wanted to go do my part for my country.

We wanted to be there, despite the hardship.[00:04.20.00]

And so you had to just be prepared and ready for the worst, but still hope for the best.

You're different than you were. Look, war changes people. [00:04.40.00]

Lieutenant James P. Blacksmith.

Lance Corporal Antoine Smith. [00:05.00.00]

It lurks behind their eyes, where the soul used to live. Eyes that have seen too much of war's bad places, of atrocities bordered by unspeakable horror that forever scars the psyche. Everlastingly searing moments that eternally burns [00:05.20.00] too bright.

Hello, I'm Tom Brokaw, and I've written about The Greatest Generation, books of memories of World War II Veterans. [00:05.40.00] Now I'm pleased to reach out to the new American warriors who have served in Iraq and Afghanistan. Part of the poem recited called Combat Eyes was composed by a Vietnam combat veteran, Curtis Bennett. His words illustrate the shock and horror experienced by many soldiers, Marines, airmen and sailors of all wars. [00:06.00.00] The dark horse images and bagpipe music are from a ceremony honoring fallen comrades at the Marine base, Camp Pendleton. This kind of ritual gives Marines a non-verbal way to grieve their loss and to heal the invisible wounds of war. Over the years the VA [00:06.20.00] has learned a great deal about combat stress and how to heal the wounds of war. Much of that has evolved from working with veterans who've returned from Vietnam and previous wars. To develop what you're about to see military and VA clinical experts shared their insights on combat, stress and trauma. [00:06.40.00] And other experts, those men and women who served in Iraq and Afghanistan, reveal their own insights and experiences.

Who can forget the morning of September 11th, 2001. [00:07.00.00] Most remember where they were and what they were doing when two commercial jets crashed into the twin towers of the World Trade Center in New York City. Shortly thereafter another jet hit at the heart of the U.S. military, the Pentagon. A fourth plane was brought down in Pennsylvania by the passenger heroes of Flight 93. In one day [00:07.20.00] thousands of innocent people were killed. Osama Bin Laden, Al Qeada, and other terrorist organizations were blamed for 9/11. The United States embarked on a goal to seek out the perpetrators and bring them to justice. The War on Terror had begun. In October 2001, the U.S. launched Operation Enduring Freedom [00:07.40.00] to capture Osama Bin Laden and his leaders in Afghanistan. In that conflict American Marines and soldiers have faced extremes of environment and terrain while battling the Taliban and searching caves for Bin Laden and his followers. Although new freedoms have been won for the Afghan people, the struggle is not over. [00:08.00.00] American troops remain. March of 2003 marked the beginning of the next phase of the war on terror known as Operation Iraqi Freedom, or OIF1.

There are some significant differences between OIF1 2003, and the start of and what we are in now, [00:08.20.00] OIF2. OIF1 again was a glorious war. We were in going to get remove Satan himself from Iraq and really make a statement to the world that America is not going to put up with terrorism.

The first phase of the war in Iraq ended when Saddam's regime fell and [00:08.40.00] U.S. forces had control of major cities such as Baghdad. As the next phase of reconstruction began, known as OIF2, resistance from insurgents and terrorist groups grew. Major conflicts erupted in cities such as Fallujah, Mosul, (tacrete) and others. Now it was hard to tell just who the enemy was. [00:09.00.00] More than 250,000 active duty, reservist and National Guard personnel have been deployed in the war on terror. Collectively, Operation Enduring Freedom and Operation Iraqi Freedom are known as the new wars.

[00:09.20.00]

In the war on terror in Iraq and Afghanistan there are no front lines. The enemy can be anywhere. Danger is everywhere.

These warriors train for these stresses. It's what they expect, and their expectations of themselves is that they will each [00:09.40.00] triumph and come through it whole and victorious. It's what they're trained to believe. They need to believe that to be successful, it's important. And our warriors are very competent and brave and strong. And so what they don't understand so well is that everyone has a limit. [00:10.00.00]

We're working with terrorists, we're working with insurgents who are specifically targeting our psyche. Terrorism's goal is to attempt to create terror. And so it is incumbent upon us in the same way that we up-armor our Humvees to up-armor our brains and minds, to have resilience and preparation. And then when a mission is completed [00:10.20.00] to take the time to be able to, to put what's happened behind us, including making use of support services as necessary.

They've been through some horrible stuff. Maybe some of their friends have been killed. But get back to the mission. And that works very well. We found that if we take people out of combat, out of the front lines, [00:10.40.00] they tend to continue the shame and stigma of being evacuated out all of their life. What we have learned through 100 years of war is that most appropriate treatment is to treat people early, up close to the front lines, with some basic principles. And we call those principles [00:11.00.00] proximity, immediacy, expectancy and simplicity.

The OSCAR program that I'm part of, Operational Stress Control And Readiness, is a new way of approaching mental health service in the Marine Corps. And it was bringing specialists like myself as far forward as we could get. As much as we could [00:11.20.00] we went forward to regimental, company and smaller areas and talked to people and saw Marines and sailors in bombed out buildings or out, out in the dirt, or many times while the bombs were still falling and the snipers were stills hooting. Because that's [00:11.40.00] when and where they were having difficulty.

After the first part of the war, in 2003, former Navy commander and neuropsychologist Dr. Dennis Reeves met with 5,000 Marines throughout Iraq. Traveling in a Humvee his OSCAR team met with them in small groups.

The groups did a couple of things. We're really practicing [00:12.00.00] preventive medicine models there. And that was the first thought is resiliency. If after a trauma you go in and you start processing and you get the emotions out and you see that other people experienced the same sort of thing that you did, that makes you feel more normal. [00:12.20.00] The times where I really had to do serious counseling was when a Marine thought that they had, had killed a civilian, a non-combatant. And especially if they had shot a child. They were devastated.

Everyone has a limit. Everyone has a limit to the magnitude of stress that they can take [00:12.40.00] at any given moment. And how long they can endure the daily relentless day after day, minute after minute, stress of being deployed.

Talking about combat stress events and normalizing common post-trauma thoughts, feelings and behaviors is an important component of managing stress. [00:13.00.00] The use of medication to help with sleep can be equally important.

Four hours a night for them is a luxury. And so sometimes to get more sleep requires changing their schedule in some way. But for the guys that couldn't sleep with the time they had any kind of medication that could promote that without [00:13.20.00] making them so sleepy and dull that they couldn't respond to an alert or something like that, very helpful.

To help with combat stress and sleep problems medications are often prescribed in theater. For example, serotonin reuptake inhibitors known as SSRIs, antidepressants like [00:13.40.00] Paxil or Zoloft, are given.

They enhance the effectiveness of the serotonin system, which is kind of like an internal shock absorber system. And it's something these guys get right away when I tell them their internal shock absorbers are worn out. And that helps them understand why they're having more anxiety [00:14.00.00] and anger and depression and some of these other things and can't keep as much of an even keel. The second way that SSRI antidepressants can be helpful in these kinds of problems is there's a couple of studies that show that SSRIs increase levels of neuropeptide Y in the brain. And neuropeptide Y is a natural occurring anti-anxiety peptide [00:14.20.00] we're only beginning to learn about. But we know that neuropeptide Y levels are decreased over time in severe stress and increase with training. But these medications can help restore them more to more normal levels, (it's a) normal anti-anxiety. So, the third way that SSRIs can help with these problems [00:14.40.00] is there's a couple studies showing that they can increase levels of brain-derived neurotrophic factor which is a naturally occurring, growth promoting, healing promoting peptide hormone in the brain that actually helps the hippocampus regrow and heal. And the fourth thing about SSRIs is that [00:15.00.00] they, they seem to be neural protective. They actually prevent further injury to the brain by severe stress.

(Prazosin) is another medication currently given in theater for sleep problems and hyperarousal.

I discovered working with combat veterans that the sleep disruption [00:15.20.00] and nightmares of combat situations appeared to be an adrenaline rush phenomenon, or more accurately, a norepinephrine excessive response—norepinephrine is the brain's adrenaline—that was persisting for decades [00:15.40.00] after it was appropriate in a combat situation in Vietnam. Fortunately we have medications that were initially developed to treat high blood pressure that block the excessive norepinephrine response.

And that's useful for some of the patients who had nightmares that would wake them up [00:16.00.00] with arousal and sweating and heart pounding. And Prazosin could block enough of the physical effects of norepinephrine so that at least they could sleep through the night and get more restful sleep.

Besides more combat stress teams and chaplains available [00:16.20.00] in country, military leaders have taken a proactive approach on military bases at home. As an example (Madican) Army Medical Center at Fort Lewis Washington state now offers combat support groups following deployment.

In group we see this remarkable sense of guilt that these incredible young men and women have that they [00:16.40.00] didn't bring everyone back home.

The reason I believe that group therapy is most useful for soldiers coming back from especially a traumatic experience of any kind is that soldiers are helping soldiers. We normalize their, their problems. We tend to allow them to feel normal in the group. And with that they recover quickly and to [00:17.00.00] try to compare with Vietnam vets, I really believe that this has just been absolutely phenomenal what we're seeing. They are getting well.

At the Marine base, Camp Pendleton, and other military bases, they're launching similar groups to help build resiliency, especially for those who may be redeployed.

Our services include individual counseling, [00:17.20.00] couples counseling, family counseling, as well as group counseling in several different formats. Primarily it's a brief solution-focused. The military being a very deploying military and moving around a lot, we don't offer long-term counseling services, [00:17.40.00] not here at this agency. But this would be something which we would refer out.

Some of our finest heroes struggle coming back from the war. As an artilleryman for the Marines, [00:18.00.00] Andrew helped provide firepower in the rescue of American hostage, Jessica Lynch. Following his second deployment in Iraq and his return home, Andrew realized that he was having problems with anger and anxiety. He sought help at Camp Pendleton.

I found I was experiencing the same type of anxiety at home [00:18.20.00] in a simple movie store. Having potential threats at all times just kept you on edge so much that you couldn't relax anywhere. I did have a dear close friend die out there in Iraq. And remembering the times [00:18.40.00] that we were out there and the operations that we did conduct, it seemed at times you were reliving that. That at times you could be in a big city and it was almost as if you were back in Iraq. I started to get angry over small tidbits that really should not have mattered [00:19.00.00] to anybody. Anxiety was a big one. Loss of memory. I couldn't recall what it was that I had just done with a set of car keys 15 minutes later down the road. The realization that helped me step off and get help

where possible was the fact that [00:19.20.00] if I could notice a difference in myself, that I'm sure it looked even more so to my own family and friends. Even if there's a little bit of doubt in your mind that there's a problem, that it would be better to ask and find out rather than, like myself, eight months down the road find out that, hey, you know what, this has [00:19.40.00] really blown into a big problem. It has definitely done a lot for me and I feel that this is honestly one of the best things that I've done in my time in the Marine Corps.

But unlike Andrew, many [00:20.00.00] military men and women share away from mental health providers. They're afraid it will hurt their image of being strong and fit for duty. Yet they may reach out to a chaplain in times of stress. To talk to a chappie feels emotionally safe, and doesn't imply that one has mental problems. It also doesn't carry a negative mental health stigma. [00:20.20.00]

Not only do we as chaplains have the freedom to go with our soldiers wherever they go, we also have chaplain assistants. And they can notice issues and problems with soldiers, make us aware of that. And we can actually seek them out. Often they do come to us and knock on the door. We had a steady stream of people coming in for counseling. [00:20.40.00]

The chaplain's going to be a listening ear. Hopefully he's going to have some, some advice, some counsel to give to them. Also they know that when they come to the chaplain for the, for the majority of things it's confidential.

We found that it was very helpful over there to just say, "Hey, hop in the Humvee, we'll take you down to combat stress," and help them check in. [00:21.00.00] And we also go to tap into the resources of combat stress. Chaplain (still I) needed someone to talk to too, and we found him very helpful in debriefing us in all the things we'd seen and heard. The big things that we noticed is that the soldiers going through an incident, the National Guard had often [00:21.20.00] known each other for a long time, and just a lot of stress on the level of family type stress, friend type stress, fellow soldier stress. The combat losses were much more traumatic because of the relationships of the soldiers.

One of the things I learned serving in Iraq is what hero [00:21.40.00] soldiers are. I was just amazed at the things that a soldier will do that I don't think any other person does. I went out on a recovery mission. We had a Humvee that had been hit by an IED. And they had dug these guys out. They had done the best medical care they could for them before they got them on the chopper. [00:22.00.00] And again, you know, they put more into that than any football player ever put into playing the football game or baseball player ever put into the World Series.

Despite heroic efforts, all wars bring injuries and death. The injured of the new wars, however, have not only quicker access to medical care, [00:22.20.00] but to improved medical care.

Tim, a scout platoon leader with the National Guard left his wife and two small children when his unit was deployed to Iraq. In country for seven months, [00:22.40.00] his Humvee was hit by an insurgent's homemade bomb, also known as an improvised explosive device, or IED. The explosion left a six foot hole in the ground. Tim was severely injured with a broken back and unable to walk. And his wife Connie, a battalion family support coordinator, was left needing support [00:23.00.00] for herself.

We hit an IED which basically pretty much destroyed the vehicle, wounded my driver pretty bad. The sniper had minor injuries. I had a (reverse) fracture on my alpha vertebrae and it ended up killing my gunner the next day (in lungstohl). [00:23.20.00] He was airvacced that evening to (lungstohl). My driver and I were airvacced the next day. (while at) the cash I was able to call, call my wife.

As a battalion coordinator I had gone to casualty training. So, they—[00:23.40.00] you know I was told what would happen, I was told what notification would happen. But when it happens to you it is, it is something totally different.

She actually got to Germany about two days after I arrived there. In hindsight that's probably the best thing the Army could have ever done, probably ever done [00:24.00.00] for me, is having my wife there in Germany with me. I, I really had no trouble dealing with any of the issues, you know, post-traumatic from it or anything. And I think that's, that's largely because of having her there. I saw a lot of guys in the hospital that didn't have family members there and they, they definitely had a much harder time [00:24.20.00] than I did.

I was there for two and a half weeks, because they wanted to do Tim's surgery there. They were afraid to move him because of the nature of his injury. They wanted him to stay there. So, I Had a place to stay, which was very good. It's called the Fisher House, amazing, amazing place.

Two titanium rods were surgically implanted [00:24.40.00] to support Tim's spine so he could walk again. He spent the next six months recovering, first in various military hospitals, then later at home. The injury could have been reason enough for Tim to stay out of combat.

I chose to return to Iraq because I'm not medically disabled. I refused to consider that as an option. [00:25.00.00]

I knew he was going to want to go back. And I tried to prepare myself for that, although you really don't prepare yourself for that. So, I would just tell him, "Let's just take it one day at a time." You know, I didn't want him to be disappointed. But I also didn't want to disappoint our girls too.

Who's going to the zoo?

You're going to go to the zoo today?

Me.

Me.

Those two girls has probably been the most therapeutic [00:25.20.00] for me, because they're always right there. Connie has been a single parent. She's had to take care of both our daughters, works a full-time job, has been the family support coordinator. The job I had in Iraq was much easier than the job she's had here. And being home for that long it really gave me a good perspective because I got to see [00:25.40.00] both sides of it.

Tim and his wife, Connie, pulled together as a family through their stressful ordeal. Like them, most military families have their own fears, anxieties and stressors while their loved ones are away.

Both the Army and the other branches of the service [00:26.00.00] have recognized, for us—where the advantage is for us for the Guard and Reserve that families are the key to readiness. So, in recognizing that they've thrown some money at it that we didn't have before. The money allows us to provide resources at the level where the families are. Not only on military installations, but in [00:26.20.00] their local communities.

Individuals don't recover by themselves. That if a soldier, sailor, airman, Marine has an issue then their entire family has an issue. Because they have an effect on their family. And we want to be able to provide services not only for the veteran but for the entire family, so everyone's on the same page. In addition to that, [00:26.40.00] families have their own specific issues and they're extremely significant. The separation is a huge issue. I mean in the best of circumstances just being separated is very, very challenging.

In the new wars surgeons [00:27.00.00] and medical care are placed much closer to combat areas. When he arrived in country, Captain McDonald soon discovered the dangers involved.

Actually only a week or so after I arrived in Fallujah we took over a facility from an Army group that was due to rotate home in five days. And a mortar came in [00:27.20.00] and actually killed their surgeon and injured eight or nine medics, killed an Army medic also. And that particular event really brought home to the medical folks over there that gee, not only are we over here providing (good) but we're integrated into an environment [00:27.40.00] where we're at risk also.

In previous wars, almost 30% of the soldiers would die from combat wounds. But today as a result of improvement in head and body armor, more are surviving multiple serious injuries. Only 10% of combat wounds are fatal.

And the reason for this is that [00:28.00.00] we do have better body armor, there's better protection, and also there's better battlefield medical care available. So, people can be severely injured and survive. And because of this we do see more residuals of very severe injuries. Whether they be amputations, spinal cord injuries, head injuries, blast injuries. [00:28.20.00]

The signature wound from this war may well be traumatic brain injury. With the severely wounded we pick that out, they're in the hospital, we recognize it, we'll treat it. But what we're very concerned about is those who may have mild brain injuries, concussions, who don't come to you saying [00:28.40.00] they've got a traumatic brain injury. Instead they may present with issues about irritability or not getting along with their family or problems concentrating, which are all consistent with traumatic brain injury but also could be consistent with posttraumatic stress disorder or just coming home from war. [00:29.00.00]

You might think that oh, just being knocked out for a little while then coming to again and going about your daily business is a normal, okay thing. There are some significant things that can occur in that concussive event.

A recent study published in the New England Journal of Medicine on the new wars found that 65% or two thirds [00:29.20.00] of combat wounds resulted from a blast injury.

In additional to the shock wave coming at you there might be deflectors like somebody standing in front of you, your body armor also helps shield you. But that shockwave, the explosion, frequently will pick you up and slam you back down. So, you will get both a blast injury [00:29.40.00] as well as a concussion as well as you know it blows parts of your body off as well.

Therefore, it's really important for the provider to screen for traumatic brain injury, to ask questions about exposure to blasts and other trauma, and also questions about difficulty concentrating, [00:30.00.00] difficulty remembering, other symptoms of mild brain injury.

Symptoms of blast are very similar to (we expect) concussion. You will have slowed memory, short term memory problems. You'll have very slowed thinking. You'll probably have balance problems due to the inner ear effects, [00:30.20.00] and possibly hearing, and vertigo, as well as irritability.

Others with a head injury can have emotional outbursts or appear socially clumsy. And when fatigued the patients may appear more memory impaired or confused. Sports concussions are the closest thing to traumatic [00:30.40.00] brain injury. So, to test for mental ability, attention and memory you may want to use the Sideline Assessment for Concussion, also known as SAC, or the Mini Mental State Exam. When working with clients with a head injury it's advised to speak slowly and clearly, to repeat things slowly, [00:31.00.00] use more pauses so that the patient can catch up, provide written

information or record on video or audio for the client's review at home. To help treat these injuries the Veteran's Health Administration has set up four polytrauma rehabilitation centers. They're located in Richmond, Virginia, [00:31.20.00] Tampa, Florida, Minneapolis, Minnesota and Palo Alto, California. These polytrauma centers allow veterans to be moved from acute care to receive comprehensive rehabilitation services. The goal is to return VA clients to their home community and offer support to families. Some VA medical centers, [00:31.40.00] such as the Seattle VA have a deployment health clinic for new returning veterans where they can see a physician and mental health counselor all in one place.

All Iraqi Freedom, Enduring Freedom veterans who come into our system go through that clinic. So, our goal here is early intervention which creates an optimistic [00:32.00.00] outcome. And the orientation of the program is really one that emphasizes wellness, rehabilitation, with an expectation of full recovery. These are typically time limited treatment approaches that involve health education, targeted cognitive behavioral treatment for some of the salient problems that they have [00:32.20.00] like anger, stress. And of course family integration is a big problem.

I always want to know when they were in country, because different times during the conflict have been—there have been different sorts of risks, where they were in the country, what their job was while they were in country. We want to know about environmental exposures. We want to [00:32.40.00] ask about whether what sorts of combat traumas they may have been exposed to. Do they take hostile fire? Did they see casualties? Did they insist in the care of any wounded individuals?

Although we think of the war as a single event, actually it's really a series of events that are [00:33.00.00] experienced by individuals. And the effect that that has on each individual varies depending on their personal constitution and their ability to deal with that stress. Good to keep in mind that although someone may have had no problems with combat stress issues for a substantial part of time [00:33.20.00] during their service or even afterwards that there may indeed be issues later. And these are always worth revisiting when you go back as a provider talking to a veteran.

Bob grew up [00:33.40.00] during the Vietnam War in the 1960s. He saw what happened to his father's generation. As a chaplain's bodyguard in Iraq Bob saw plenty of combat serving with the Marines. Now he's an Iraq war veteran and still in the Navy reserves. After his duty Bob returned to his wife and two small children and a civilian life. [00:34.00.00] He started a new job as a managing news editor of a television station.

I was really short fused with everything. Everything. My kid would cry I was—I didn't realize I was doing it at the time, but I was up all night. I sleep a couple hours a night maybe, two, three [00:34.20.00] hours a night. Every noise I was up. Every window, I was constantly checking windows and doors, make sure everything was locked. This one night he came in my room in November. And we're in (writings) and I'm back on the night shift and it's really stressful. And he comes in, "Waa waa, daddy, daddy up," which

means pick me up. [00:34.40.00] I'm like, "Go to bed." I got down the hallway with him and he was just screaming. And I grabbed him up by his arms and I had him up like this and was just shaking him saying, "Shut up!" just screaming at him. And I caught myself, and I'm like, oh my God. And his face was just horrified. [00:35.00.00] And man I just, I put him down and said—he had a toddler bed. Of course by now the baby's screaming. My wife's up, "Oh my God, Bob, oh my God. Put him down." And I set him down on his bed, and I just sat down next to him and I just start crying. I was like, oh my God. So, we had a nice little talk after that, my wife and I did. And that's when she [00:35.20.00] broke out the list. "Here's all the problems you've been having you need to know about."

Bob remembers this incident and his wife's comments as sobering, a wake up call. The next day he went to work early and found the VA Web site.

Well, they had a thing on there for OIF and OEF [00:35.40.00] veterans. And I thought, well this is weird. So, I clicked on it. And I started looking and it talked about post-traumatic stress. And so I went on the site and I started looking at a couple of the things and they had a little checklist. And I was like [laughs] got it, got it, got it, got it—I got to the bottom, I was like man, got it, oh there's one I don't have,[00:36.00.00] got it, got it, got it. All right, maybe I need to send an e-mail to somebody. And then down at the bottom it said if you have any of these issues—so I sent an e-mail. And within an hour I got a response back from a guy up in Vista. And about an hour after that I got a call from Karen, my counselor. And she said, "How [00:36.20.00] soon can you come see us? I need to assess you." And so we were in our first session and we sat down, we talked about it. And I said, "I am not here—" and I pointed my finger right at her. I said, "I am not here for a disability and I am not here for anything else." She says, "Well, here's your e-mail. [00:36.40.00] Let's talk about it." And instead of attacking—but she's pretty strong, she checks me. She says, "Wow, the normal person usually scores a 12, a normally stressed person usually scores a 12 out of 50 on this. You scored a 43. We need to talk about medication, Bob." And I said, [00:37.00.00] "Right. We ain't talking about medication. I'm not taking no medicine." Arms go up again and I'm like, you know, "Forget it. Not me. You're not going to dope me up." And she said, "Why?" I said, "Because I'm not going to turn into one of these slobbering zombies or somebody who's, you know, hanging around the VA trying to get their [00:37.20.00] refill or whatever it is you give them, lithium or whatever." And she, she said, " I want you to do me a favor. I want you to think about it." Gave me some literature, gave me a Web site to go look at. I talked to some of my family members, including my wife, about medication. And we all came to the consensus that this would be a good thing, not a bad thing. So, I started on it [00:37.40.00] a couple months ago. And I asked my wife just the weekend before last, I said, "Have you noticed any difference in me?" She said, "Uh, yeah! You sleep at least four hours a night now, sometimes six. You—the depression's gone away sort of. [00:38.00.00] You're calmer. Situations where you were flipping out over now you're just calm."

Now this Marine veteran not only is involved in counseling, he volunteers his time and gives talks to other veterans about war and stress.

And I don't think you're going to see all of us coming in looking for the handout. We're coming in looking to get wired and go back out [00:38.20.00] so we can have productive lives and live our lives and, and be involved and be proud of what we are, you know. Not feeling like we're a bunch of crippled, broke people that nobody loves.

Many veterans and active duty personnel return from war only to face continued symptoms and their own war within. [00:38.40.00] During the Civil War they called it Soldier's Heart. n World War II it was known as shell shock. The name posttraumatic stress disorder, or PTSD, and its criteria were developed after the Vietnam War. Studies suggest that 15% to 20% of Vietnam veterans meet the criteria [00:39.00.00] for PTSD. Many also suffer from depression, panic attacks and substance abuse disorders. And a recent study in a sample of Army and Marines finds that approximately 17% or one out of six Iraq and Afghanistan returnees have readjustment problems such as PTSD, depression or generalized [00:39.20.00] anxiety disorder.

Most of us as combat soldiers when we come home we have some transitions to make. And most of us are going to do fine. You know, we're going to adjust and we're going to be able to come back into the community and do, do well. Some soldiers know—some soldiers may need [00:39.40.00] a little bit more assistance in terms of getting information and assistance in making those transitions.

Common response to traumatic stress include acute stress disorder, symptoms that occur within one month of the trauma and include being easily startled or being hyper vigilant, experiencing problems falling [00:40.00.00] or staying asleep. Other common reactions include depression, general anxiety and panic attacks. There's also adjustment disorder, where a response to excessive stress results in emotional overload, [00:40.20.00] or impaired social or occupational functioning. And another common problems for returnees is posttraumatic stress disorder, or PTSD. These symptoms last more than one month and include emotional numbing, heightened arousal and hypervigilance, sleep onset and maintenance problems, [00:40.40.00] nightmares, feeling isolated and alone and having intrusive thoughts or memories of the traumatic event. Sometimes individuals may have what we call flashbacks, where they think, feel and act as if they were reliving a traumatic event, like they're back in time. [00:41.00.00] PTSD commonly occurs after traumatic military experiences such as firefights and other combat situation, seeing someone gravely injured or dead, being held as a prisoner or being tortured, handling the bodies or body parts of the dead or being the victim of a military sexual assault. Symptoms of [00:41.20.00] PTSD can occur immediately after a traumatic event or may have a delayed onset which can occur months or even years after the trauma.

The likelihood of having a problem, PTSD or otherwise, is very much dependent upon the dose of trauma. The more intense, the longer the duration or the more severe the trauma [00:41.40.00] the more likely you are to have PTSD or depression or some other

related mental health problem. So, as health care practitioners we need to know what experiences people have had—how long they were in country, how much they were exposed to death and dying and the horrors of war—because that will be a very good predictor.

The other thing is to keep in mind that veterans [00:42.00.00] are not coming to the VA with a trauma story in mind. They're experiencing the stress. It can be manifested in aches and pains, concern that something is medically wrong with them, somatic complaints come to the fore. So, it's important to take those complaints seriously and to [00:42.20.00] follow up with laboratory assessments or a physical exam as needed to reassure both the patient and the therapist.

Some of the symptoms that the primary care providers might look for are things like nightmares, things like panic attacks, chronic pain, [00:42.40.00] difficulty sleeping, isolation, substance use, those kinds of things to alert them that there might be a need for a referral to mental health.

The primary care, PTSD screen is a four item question set that can be used to screen a veteran for possible history of trauma and PTSD. [00:43.00.00] Questions focus on current symptoms and can assist a clinician regarding a need for further mental health evaluation to the client.

It's important that we take the time, that we try to understand that there possibly will be different forms of expression, different ways that emotions will come out. [00:43.20.00] So, it's about not assuming that because we're so well experienced in treating combat stress and other illnesses that could be comorbid with these, but to look for the differences. Men and women are not the same. We all know that. But literally we have to understand it and put it into our practice. [00:43.40.00]

Currently both active duty and veterans often shy away from mental health services. Reasons include fears that, "They'll lock me up or they'll think I'm crazy." There's a fear of retaliation, "I'll be punished somehow, or discharged. [00:44.00.00] They'll think I can't be counted on anymore." And there's the outright denial of problems.

I think the biggest challenge to getting people to come in for help is really the stigma that's out there. You know it's not the veteran themself that they're—it's the person next to them, they're worried what that person's going to think. [00:44.20.00] So somehow we have to make it okay and get people to understand that it's okay to seek help.

As providers it's important to educate your clients about combat stress, and to reassure the veteran that what he or she may be experiencing is a normal reaction to out of normal events. If possible [00:44.40.00] and appropriate, avoid using mental health diagnostic labels such as PTSD which the client or others might see as stigmatizing. Instead, use a phase of life problem, or an adjustment disorder as a provisional diagnosis. This can be

especially relevant to recent veterans, active duty, National Guard or reservists [00:45.00.00] because they could be redeployed.

There are those veterans who are still active in the National Guard or the reserves or are seeking employment with the police or the fire department who feel that if they have a formal diagnosis of posttraumatic stress disorder this will impair [00:45.20.00] their career. In those veterans I'm more circumspect about making a formal diagnosis by DSM-IV criteria at least for a while.

For example, what's the soldier here for? And it's post deployment adjustment. Maybe we're talking about combat stress. Tell you what I (V code) an awful lot until [00:45.40.00] later on in terms of phase of life. Anyone coming back from a deployment is going through a phase of life issue. Perhaps I run the risk of being imprecise, but I can always talk to a provider through a confidential e-mail or mostly on the phone or in person if there's really an issue to talk about there. [00:46.00.00]

The ravages of war and conditions in country can challenge our emotional, spiritual and physical strength. Imagine needing to be like your weapon, in top form and ready to go on a moment's notice, in extremes of heat or cold or battling sandstorms with little or no relief. Whether it was Iraq [00:46.20.00] or Afghanistan, conditions could be unbearable.

I got there in January, and it was raining and it was miserable and everything was flooded. And then once that dried up and it got nice then it was too hot.

I knew it was going to be hot. I had no idea that a human being [00:46.40.00] could survive such heat, especially with all the gear that we had to wear. You know, we had to keep our sleeves down, had to wear our flak vest everywhere. It's incredibly hot. It would routinely get up to 130, 140 in the summer.

The port-a-johns, thank God for those. Once we got up in this unit there were not port-a-Johns. [00:47.00.00] We had a portable box, two seater, where you sat back to back with another person and used the hopper. They actually have a couple pictures of us out there, you know way out in the flat desert like nobody could see you.

Many parts of Iraq and Kuwait blast with sandstorms that [00:47.20.00] obstruct your vision and make life somewhat miserable for you.

There is a little bit of uncomfortableness I suppose in sleeping areas. We're always trying to figure out where can the men sleep, where can the women sleep. In the Army oftentimes everybody just sleeps in the same barracks area, the same tent. We don't have the luxury of separate quarters. [00:47.40.00]

Everywhere you go you're just sweating and now it's drink water, drink water, drink water, and you just get so tired of drinking water. And it's just hot and miserable, and the

sand is all over—it's in every single thing is the sand, everywhere. Everywhere you go. [00:48.00.00]

VA providers are used to treating Vietnam veterans and veterans of previous eras. In fact it was following the Vietnam War that researchers were just beginning to understand PTSD. Before that, despite the best intentions, combat veterans were often misdiagnosed as schizophrenic or psychotic. [00:48.20.00] Many veterans stayed away from VA and tried to self-medicate with drugs or alcohol to ease their suffering. Over the years the VA's knowledge and experience base grew.

As you know the VA has been the leader in the field of trauma for over three decades now. We've learned a lot over time. But one of the things [00:48.40.00] that we're now faced with is this diverse population. So, some of the treatments that we're so familiar with and comfortable with might not be appropriate.

Now VA providers are challenged again to prepare and train for this new group of veterans and active duty needing care. So, who are these new warriors? [00:49.00.00] They're more diverse than in the Vietnam era and in previous wars. Those veterans were mainly drafted or enlisted. About half now are enlisted and in their 20s, the other half are older, enlisted active duty or in the reserves or National Guard. They range in age from the 30s to the 60s. [00:49.20.00] And unlike those that deployed to Vietnam, many are married with children and some are grandparents. Most left jobs or careers when deployed. While most faced a one time deployment of 12 to 13 months in Vietnam, many serving the new wars are facing redeployment. [00:49.40.00]

With about 50% again of the active force in Iraq being National Guard and reserve folks, that's not what you saw in Vietnam where most of if not all of the soldiers were active military, were very few National Guard and reserve folks in the composition. That's made us tailor our outreach activities [00:50.00.00] and services to this group because that group is much more dispersed.

This particular generation, they're—they have greater access to information. So, I'm not going to say that they're smarter, I'm going to say that they perhaps more aware [00:50.20.00] of the issues surrounding them. They're more aware of their theater of operations, they have instant access, e-mail, they know the things that are going on. So, their (feelings) is a little bit different. They're not as—they can't be kept in the dark.

Additionally I think the fact that they do multiple tours, [00:50.40.00] so the family will go through one transition as they deploy. They come back and they may be redeployed again, as an additional factor in the way we address these issues and tailor our services to fit them.

So, knowing that, we have to understand that the young folks will probably be more focused on things such as the [00:51.00.00] Internet and feel more comfortable in using things that are not as intrusive in terms of treatment. And at the same time, those who are

a little older would probably prefer a more personal individual sort of interaction. So, we are challenged. We have many skills, many tools, but we need to make sure that we're using the most appropriate [00:51.20.00] tool for the individuals that we're going to see.

In the war on terror American military women have played a vital role. Like their male colleagues many have also faced the struggles of deployment, [00:51.40.00] combat stress, injury or other military stressors.

This is the first time we're really seeing large numbers of women in combat, and we don't exactly know what to expect. We don't know what the long term psychological consequences are going to be. However, we are doing research on that and we are following women [00:52.00.00] both in the battlefield and after they get back home to see how they do. It can be slightly different for a woman over there. She can be feel vulnerable because there may be fewer of her or she may feel targeted by the other side. So, women do have some unique stressors. But most of what they face is pretty much the same as men [00:52.20.00] as far as danger.

In the Iraq conflict there are a lot of job titles that women hold. A lot that see combat I would say are mostly the drivers. A lot of drivers are out there. You have the medics that are out there that they see a lot.

You're going to have women who have suffered and experienced similar type of injuries as their male counterparts, such as traumatic [00:52.40.00] brain injury. We've experienced amputations or become blinded by explosive devices.

As female officer I was the only female lieutenant. And it was a little different for that reason. I didn't feel like I could ever show feelings or weakness.

The biggest problem that I faced as a woman was the fact that [00:53.00.00] in the unit that I wound up going over there with, most of the chain of command were kind of like old school type guys. And some of them seemed to take it as their personal mission to prove that a woman really couldn't hack it in the military.

Did have an incident where driving through a town, [00:53.20.00] had to go real slow because there was so many kids in the road. Rolling through about five miles an hour and a kid probably about 15, 16, 18 came running up to the side of the Humvee and reached through the open window and groped me, and laughed.

We also served with fellow Iraqis, I did where I was at. And that was kind of hard because [00:53.40.00] of course the way that the Iraqis that I worked with, the way that they treat the women and the way they see the women, women are very, very low in their society.

Military women can face different adjustment issues. [00:54.00.00] Although the role of women in today's military has changed some women still feel treated as second class

citizens. They also feel pressure to handle a job as well as a man, or their authority is often challenged.

I just began seeing a young Iraqi veteran who recently returned from Iraq. [00:54.20.00] Presented extremely tearful, depressed and anxious. And she was in a leadership role in Iraq. And she had about five young men working for her. Non-compliance. Disrespect. Constant having to discipline them. [00:54.40.00] And so when she returned she was extremely angry but never able to express it in Iraq, and also worried about the fact that these young men were responsible for the security of the unit.

Sexual assault remains a threat for many women in the military. Many don't report it for fear of negative consequences such as ridicule, [00:55.00.00] reprisal, demotion or discharge.

Sometimes they will say that their experience afterwards was far worse than the rape itself, simply because they didn't get acknowledged or validated as far as the rape goes.

And for female clients who experience [00:55.20.00] military sexual trauma, it can be very difficult to impossible to undergo a pelvic examination and treatment by an OB-GYN physician. Understandably, due to the nature of the OB-GYN exam there are aspects that possibly remind the women of a traumatic time, a loss of control, being invaded, [00:55.40.00] losing integrity, so that woman may avoid care.

You know it's important for providers to understand that, and again patients working with them so they can become more comfortable. This is a huge medical need to have taken care of.

No longer is it women are veterans too, women are veterans. [00:56.00.00] Women because of that status they deserve and are eligible for equitable health care, provided by sensitive and compassionate providers who acknowledge and accept their contributions equally in service to their country. [00:56.20.00]

A recent survey finds VA medical care to be one of the top in the nation. But for many male and female veterans VA represents the government, and therefore can't be trusted. so, they avoid getting that care. With this in mind [00:56.40.00] our new warriors shared their insights on how to build rapport and trust.

Soldiers are people. And especially guys that have—guys and women who have gone through some of the experiences that people have in Iraq, definitely do not want to be treated like a number. They're people.

I just would like them to be able to answer questions. [00:57.00.00] You know when—give as much information as you can to the family members. And I think the biggest

thing is I think every soldier should have somebody with them when they make decisions about their healthcare.

Let the story come out before they try to interpret what the soldier's saying. Just let, let the soldier start from beginning to end [00:57.20.00] because a lot of things that the soldier may be coming in for are traumatic things.

The vets that are coming home from the Iraqi war, they're not in the same frame of mind every other patient would be in, every other normal patient would be in. They're in a different world. They're lost. And a lot of them are not even aware of what problems that they have. [00:57.40.00]

Be very understanding. Don't act like they should know everything because—in normal situations they would understand. But when they come back they have no clue.

When you're dealing with us you're going to have to be patient. [00:58.00.00] Because getting to the real problem—"Ah, dead people don't bother me, blah, blah, blah." Yeah, actually they do bother us. The other thing to remember about us is to, to be prepared to deal with us on is the fact that we all think we know better. We all think that because we've got the Internet [00:58.20.00] and TV that we know better than you, and we don't.

The new American warriors deserve the best that the VA has to offer. The VA has adopted a more diverse approach in treating their clients. Mental health care may be provided in community-based outpatient clinics known as CBOCS, [00:58.40.00] or at larger and more comprehensive VA medical centers, or in more than 200 community-based readjustment counseling centers also known as vet centers.

Here they are, warriors, men and women, who have been through hell and now find themselves suffering, in some instances, or confused [00:59.00.00] or distressed and having to come and ask for assistance. It's a difficult situation for them. And we have to do the right thing. We have to give them the time, the respect, and the understanding.

With our returning veterans in particular, patience is going to be a real issue and VA's going to need to be very sensitive. [00:59.20.00] When they are called up they're not going to want an appointment in a month, they're going to want to be seen probably that same day because it's a crisis issue.

And another thing that's useful to understand is the many different cultures within the military, the subcultures, that an infantryman has a different way of seeing the world and his [00:59.40.00] part in it than an air crewman or a truck driver or someone on a convoy or support person.

Just treat the Marine like you would treat anyone else, with empathy, a lot of hearing, listening. Cognitive behavioral therapy is really good with some of them. [01:00.00.00] Probably insight therapy isn't the greatest idea for the Marine Corps. But the fact of the

matter is VA counselors can be extremely effective in treating veterans and we need them.

Treatment that's found to be most effective for treating sexual trauma and other trauma as well [01:00.20.00] is exposure therapy, which is essentially going back to the trauma and reliving it in a very systematic way through the help of a therapist, and cognitive interventions or cognitive restructuring. Those are the two most effective therapies.

I guess another thing that would be helpful for the VA providers to understand [01:00.40.00] about the warrior culture and Marines and soldiers and sailors. And they're men and women who tend to do rather than speak. So, they get really a lot of healing mileage out of ceremony and symbol and ritual, things like memorial services. [01:01.00.00] One of our battalions here recently had a beautiful ceremony on the beach at sunset with a riderless horse and Marines putting the dog tags of each of their fallen comrades over the pommel of the horse. Not a word was spoke. The horse was passed in front of the ranks of men [01:01.20.00] in the battalion. Each would touch the horse as it went by. These are powerful ways to lead them in their process of healing from their grief.

Some VA medical centers are partnering with community [01:01.40.00] agencies to increase services to their clients.

So, we're sort of looking beyond the VA to work with local government, agencies, local non-profits. I'm working with one non-profit agency for example that specializes in parenting coaching classes, which is as you know we don't deal with children really in the VA system. [01:02.00.00] [laughs] So, it's a natural fit. We're working with a local sheriff's department, working with the local colleges, working with the employment development office. We're working with Health and Human Services because unfortunately there are a number of veterans who are involved with domestic violence and child abuse. [01:02.20.00]

We have to understand that while serving in the military the family has its own language, it has its understanding and support system. When these men and women come home they lose that immediate sort of support. And the reality, as you all know, the impact of stress can affect not only the veteran themselves, [01:02.40.00] but their family members and the community at large. So, that's why it's so central that we begin to embrace the notion of family and the kinds of services that we might have to expand or each out to in order to help these men and women recover.

The vet centers, unlike the VA medical centers, do not require a diagnosis before we treat [01:03.00.00] these soldiers. So, a lot of the family services that we provide, a lot of the work that we do, it is out of the traditional quote clinical role, is something that we can attend to. And the vet centers can very easily provide services not only to the soldier and to their family members but also to the children of these veterans. [01:03.20.00] And I

think in that role the VA I think very much appreciates the fact that the vet centers can add additional value to the scope and services that we provide.

As providers you have the skills to help these clients feel more normal again, and to help them learn better self-care and coping skills. [01:03.40.00] However, this also is the time to practice your own self-care and coping.

I think it's been shown in conflict after conflict that people in the caring professions, whether they're religious or medical personnel are often have the highest rates of suffering from the effects of stress. [01:04.00.00] Part of it's exposure. You're just in the place where you see a lot of it and so and it has an effect on you.

So, how do we know we're experiencing stress? Possibly if we're finding ourselves having the same dreams that our veterans report, their nightmares, finding ourselves getting agitated, feeling like we also [01:04.20.00] don't want to spend a lot of time with our families or even come to work sometimes. So, those are some of the markers that might suggest that we're getting somewhat tired.

It's probably would be a good idea if every VA center had a facilitator that could conduct regular debriefings for the counselors that was not part of the team that's doing the assessment [01:04.40.00] of PTSD every day and not conducting PTSD groups every day. Because if you don't you will end up a victim of secondary PTSD. You'll burn out.

The VA and DOD have formed a new partnership [01:05.00.00] to embrace OIF, OEF warriors coming home. The VA Office of Seamless Transition is working with the DOD to ensure a smooth transfer from DOD to VA. Many VA medical centers, vet centers and all regional offices have outreach efforts now underway. [01:05.20.00]

For the first time in history the VA is providing two years of free health care for combat veterans from countries that are part of the global war on terrorism, primarily in Iraq and Afghanistan. And this two years of free health care is from the date of separation from active duty. So reservists are qualified for this program as well, and National Guardsmen. [01:05.40.00]

Former Navy commander and outreach counselor Mike (Olson) knows first hand the urgent need to reach these returning veterans early. Mike recently lost his nephew, a young Iraqi war veteran, to suicide.

I've lost family members. I have three serving active duty members. All of us have served in Iraq, I'm the fourth. [01:06.00.00] And one of those young men, my nephew, is dead as a direct result of his good and effective military service. Not in country, but out of country by his own hand. So the issue is, is it life and death? Well, it is for my family. And is it life and death for other people's families? Absolutely.

This is a time now for [01:06.20.00] those of us clinicians in the VA and in other institutions and agencies and for the veterans to come together. What we don't want to see is another population, another era lost to (chronicity) and other complex comorbidities. Remember we don't want to see these men and women struggling 20 [01:06.40.00] and 30 years from now.

Continue building bridges with the new American warriors, and thank them for their service to their country. Communicate in a way that fosters being understood. Clinical experience [01:07.00.00] and the input of veterans suggest that VA providers consider the following in treating their clients. Offer basic respect, sincerity and a sense of hope. Ask questions and listen attentively and patiently to responses. Allow these new warriors to teach you. Keep in mind patient confidentiality. [01:07.20.00] And if appropriate, avoid charting potentially stigmatizing diagnoses. Ask about your clients' personal historical background and current family, work status. Learn as much as you can about the military and your clients' jobs and duties. Ask about the veteran's military experiences, [01:07.40.00] especially those that were traumatic. Ask if they may have experienced a blast injury or a concussion. Convey a sense of collaboration, both provider and veteran working toward a common goal helping to minimize or resolve mental distress or physical symptoms. And consider implementing various treatment approaches. [01:08.00.00] Medical, behavioral, psychosocial and cultural for adjustment issues or physical issues. Time is of the essence. Do your part to reach out.

All VA providers have the privilege of serving this [01:08.20.00] new diverse group of warriors. Learn from them as they will learn from you. Remember many are suffering physical, psychological and spiritual wounds from their military experience. Support them in their efforts to heal. Recognize that they and their family members have faced enormous challenges and made huge sacrifices for their country. [01:08.40.00] You have the tools that can save lives and make a difference. Now it's your turn to serve them, help them to be resilient and to reach their full potential. [01:09.00.00]

We're proud to have brought you this program on combat stress and wellness. We hope you gained some valuable training. And all of us [01:09.20.00] in the VA, DOD and Congress want to help our new warriors as they transition to civilian life. You are the first line in that endeavor. As healthcare providers I hope you will treat each individual with the care and the respect that you would give to your own family member. Each deserves the best from us. [01:09.40.00] We appreciate your efforts and your devotion to our new veterans from the global war on terror. And for all veterans for previous wars. Thank you for your compassionate care. [01:10.00.00]

[end of audio]