Florida Alcohol and Drug Abuse Association, Inc.

Combat Stress and Substance Abuse: Understanding the Challenges Experienced by Veterans and Their Families

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National Demographics

- Over 1.6 million U.S. Forces have deployed to Iraq and Afghanistan

  49% Former Active Duty

  51% Reserve and National Guard
- 85 % Male, 15 % 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

Women Veterans

- The total veteran population in US and Puerto Rico as of October 2008 was approximately 27 million.
  - Women veterans number 1,802,491; approximately 7.5%
  - This number is expected to increase to 10% by 2010; women are one of the fastest growing segments of the veteran population
- More than 180,000 women have served in Iraq and Afghanistan
  - At least 450 women have been wounded in Iraq
  - 71 women have died
- As of 10/08 there are 138,342 women veterans in Florida

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 soldier leaves
- Adjustment period
- Reunion – tension may develop as family anticipates changes related to return of service member
- 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
- Spouse at home faced with managing unfamiliar tasks
- Impact of mothers being deployed
- Effect of pre-existing difficulties
- Every service member and their family members are affected in some way

Women Veterans and Family

Family issues are paramount

- Often in caregiver role
- Partner conflict
- Parenting skills
- Domestic violence
- Young children
- Individuation from family of origin

What Is Normal Reintegration?

- Dearth of scientific research
- Time varies from soldier to soldier
- Behaviors and emotions vary from soldier to soldier
- There is no set process for reintegration

Post-Deployment Readjustment

“Normal” Reactions

to

“Abnormal” Events

“Abnormal” Events

- Separation from family/friends
- Concerns about home
- Difficult living conditions
- Multiple demands, long hours
- Witnessing human suffering (poverty, etc.)
- Witnessing the aftermath of war (death and destruction)

“Abnormal” Events

- Constant threat of death/injury (mortar attacks, IEDs, etc.)
- Combat exposure, including: being shot at, firing own weapon, etc.
- 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

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 soldiers in Iraq
- "Did you kill someone over there?" "Did you get shot at?" "Why did you go?"
- What to do with all the free time

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

Other Considerations That May Impact Family Functioning

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

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Risk Factors for PTSD

Risk Factors for Combat-related Post-traumatic Symptoms

- Severity and duration of combat*
- Lack of unit cohesion
- Lack of preparation and training
  - National Guard/Reservist vs. Active Duty
- Prior Trauma- early, chronic, or single events
- Prior psychiatric diagnosis
- Military sexual trauma

Predictors and Modifiers

Vulnerability
- Age and coping skill
- Small hippocampus
- Abuse in childhood
- Antisocial personality
- Family history of anxiety or depression
- Stressful life events in last 3 months
- AOD use
- Low educational status
- Lack of or inadequate social support network

Initial Stress Reaction
- Peri-traumatic dissociation

Resiliency
- Environmental support
- Self-esteem
- Intelligence

Stressor
- Severity and proximity of trauma

How Are Our Veterans Coping?

Substance Abuse and Dependence

Effects of Substance Abuse and Dependence

- 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
- 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 (73.2% males; 26.8% females)
  - 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.

Co-morbidity with PTSD

- PTSD is highly co-morbid, 88% of men and 79% of women have at least one additional disorder.
- Among the co-morbid disorders, in 70-90% of patients, PTSD was the earliest psychiatric disorder.
- GAD and alcohol abuse are most commonly the first appearing co-morbid disorders. Followed by depression, phobias and panic disorder.
- Substance dependent individuals with PTSD are more likely to report suicidality, aggression, and psychosocial impairment at treatment onset

Common Drugs of Abuse

- Alcohol
- Narcotics (heroin, morphine)
- Benzodiazepines
- Marijuana

Veterans of Iraq and Afghanistan

- Walter Reed Army Institute Study 2003

  - 11% of returning Afghanistan vets and 15% of returning Iraq vets showed signs of anxiety, depression and PTSD

- VA Health Administration Study 2005

  - 120,000 recent veterans had been seen at the VA and more than 30% had a psychological disorder

Military Studies

- 2006 Hoge did a follow up study looking at soldiers and marines who were home for one year
- Main outcome measures were PTSD, major depression and other mental health problems including alcohol abuse

  OIF: Screening positive for 1 mental health concern

  - 18.4% of active duty; 21% of National Guard; 20% Reserve
  - 23.6% of women compared to 18.6% of men

- This study also compared deployment location with the prevalence of mental health problems (Iraq, 19.1%; Afghanistan, 11.3% & other deployments 8.5%)

Military Studies

- March 2007 Seal studied 103,788 OIF/OEF veterans seen at the VA
  - 13% female
  - 54% less than 30 years of age
  - 48% National Guard/Reserve
- 25% had a mental health diagnosis, 56% of which had multiple mental health diagnosis
- 60% of those diagnosed with a psychiatric illness were first screened in non-mental health settings; 42% were made in primary care settings
- Most vulnerable for receiving a mental health diagnosis were 18-24 year old, least likely were 40 plus except for NG/RC

Women Veterans of Iraq and Afghanistan

- 2007 – Review of records from the Defense Medical Surveillance System – medical encounters of US military service members, including active duty and reserve members

- Database contained over 860,000 records of service members deployed to Iraq and/or Afghanistan

  - 12% received a specific mental disorder diagnosis
  - highest rates seen in women (17.4%)

- 22% of women suffered from "military sexual trauma" (includes sexual harassment or assault), compared to 1% of men

Women Veterans

Comorbid Difficulties

- Depression
- Anxiety/panic
- Substance use
- Personality disorders
- Somatization
- Sexual dysfunction
- Eating disorders
- Self-injurious behavior

Suicide

- Veterans with PTSD are at high risk for suicide and attempted suicide
- First 4 months of 2009: 109 military members committed suicide including 2 members of the Coast Guard
- 2008: 128 Soldiers committed suicide (Largest number since military started to keep records in 1980)
- 2007: 121 Army and active duty National Guard and Reserves committed suicide; 20% increase from 2006; approximately 34 while serving a tour of duty in Iraq
- NG/Reserve members accounted for 53% of veteran suicides from 2001 to 2005

Accessing Services

Women Veterans - Clinical Presentation

- Interpersonal problems
- Social isolation
- Identity disturbance
- Impulsivity
- Emotion dysregulation
- Numbing/dissociation
- Problematic thinking

Specific Needs of Women Veterans

- Less in-service social support
- Different determinants of social support
- Role transition
- Intimate partner violence
- Behavioral health
- PTSD – SUD co morbidity
- Military sexual trauma

Exposure to Military Sexual Trauma

Psychosocial complications:

PTSD, increased suicide risk, major depression, alcohol or drug abuse, long-term sexual dysfunction, disrupted social networks, occupational difficulties

Other Medical conditions:

breast cancer, heart attacks, obesity and asthma

Screening, Brief Intervention, and Referral to Treatment

- Initial screen for alcohol/drug use and PTSD
- Screen for PTSD
- Important to understand:
  - Culture of the military
  - Culture of war
  - Family dynamics
  - Special concerns for Guard/Reserves
  - Returning home stressors
  - Personal views
  - Stigma

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 three items.

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

Screening, Brief Intervention, and Referral to Treatment

- Brief Intervention – may include discussion/education about the effect of alcohol use on PTSD, sleep, anger and irritability, anxiety, depression, and work or relationship.
- Referral to Treatment – more intensive care outpatient or residential may be needed.

  ****The existence of PTSD and alcohol use disorder makes both problems worse – best to make referral to PTSD specialist who also has experience in treating addictive disorders

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

Treatment Approaches

Pharmacological Treatment

Anti-Adrenergic/ Anti-adrenalin

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

Benzodiazepines

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

Atypical Antipsychotics

(e.g., Seroquel, Resperidone, 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)

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

Psychotherapy Interventions

Dialectical Behavior Therapy

Eye Movement Desensitization and Reprocessing

Motivational Interviewing

Group Therapy

PTSD and the Family: Common Problems

- Family violence
- Conduct disorder
- Peer relationship problems
- Family attachment difficulties

Family Coping With PTSD

- Learn about effects of trauma
- Obtain and comply with treatment
  - May include psychotherapy for individual family members
  - Family therapy important
  - Support groups
- What if the traumatized member refuses treatment?

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