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Rod Van Pelt
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Post-Traumatic Stress Disorder in Veterans Returning from Combat: Impact on Social Reintegration

Rod Van Pelt

Abstract

Post-traumatic stress disorder (PTSD) is a mental health condition frequently observed in soldiers and veterans. The reintegration of veterans returning from combat is a challenge that state and federal administrations, as well as civilian structures and workplaces, face routinely. Despite PTSD being a public health issue with a socioeconomic impact, non-scholarly debate is the primary source of information on the non-medical burden of PTSD.

The majority of scholarly evidence focuses on PTSD primarily as a medical condition, including when addressing the problem from a socioeconomic standpoint. In fact, most of the recent scholarly evidence points to specific areas of PTSD, such as the psychiatric symptoms and their effect on behavior and interpersonal interactions, but fail to provide a comprehensive review of the condition and its overall impact in the life of the returning veterans.

This review leverages references from a wider time range to present an overview of PTSD from doctors and researchers on how to best address this problem. Most of the authors agree that medical intervention is the most important approach to help veterans with PTSD regaining their role in society. There is ongoing debate on whether the medical treatment has to be paired to other social-based interventions.

Research Question

How does PTSD impact social reintegration of veterans returning from combat?

Research Aim

To review existing evidence and assess the strength of the data supporting the research question.

Evidence Review and Assessment

Impact of combat traumatic experiences in developing PTSD

"*The constant threat to life and the gruesome sights and sounds of war take their toll on the soldier, psychologically as well as physically*" (pg 11). This quote from

Zahava Solomon accurately depicts the foundation of post-traumatic stress disorder in veterans (Solomon, 2001). The most recent wars in Iraq and Afghanistan, with their returning veterans, have raised awareness of the mental, behavioral, and social challenges associated with this disorder.

An interesting study from Solomon and Mikulincer (2006) demonstrates that war zone stressors, like combat stress reaction (CSR) can lead development of PTSD over time. In this study, the authors analyze the results of a study in two groups of veterans with and without previous CSR from 1982 Lebanon and followed up to 20 years. The subjects did not significantly differ in age, education, rank, and assignment. Despite some restrictions related to the subjective nature of the individual response to combat stress, the sampling procedure made sure that soldiers in both groups were exposed to similar amounts and types of objective stress. Clinicians trained and experienced in the diagnosis of combat-related reactions made the CSR diagnosis. Soldiers in the CSR group experienced a variety of physiological (i.e. loss of bladder and bowel control), mental and emotional symptoms as well as behaviors "*under condition of combat, invariably interpreted by those around him as signalling that the soldier, although expected to be a combatant, has ceased to function as such",* as per Solomon's direct quote in his book "Combat Stress Reaction. The Enduring Toll of War" (Solomon, 1993, *Isr J Psychiatry Relat Sci,* pg 12).

The study employed a 'validated assessment scale' to measure the presence and severity of PTSD across the two groups over four evaluations (1, 2, 4, 20 years post-Lebanon war). The data, collected in 131 CSR and 81 comparison patients who completed all four point assessments, showed that the CSR group had 6.6 times higher risk of developing PTSD when compared to the non-CSR group, with higher a probability of symptom recurrence or exacerbations. The results of the study are convincing because they not only provide a quantitative evaluation but also include a qualitative assessment of changes over time and across groups. In fact, the two groups differed not only in rates but also in the number of symptoms. At all four times, the veterans with combat stress reaction showed more posttraumatic symptoms than the veterans without combat stress reaction, and these symptoms were more severe.

This last point is especially important since the majority of the PTSD observational studies (i.e. Horesh et al., 2011 and Clancy et al., 2006,) are limited to a quantitative assessment of the presence of PTSD or its risk of post-combat appearance. Eventually, a qualitative assessment of symptom progression and severity is crucial to find a rehabilitation protocol for effectively and successfully managing PTSD patients.

PTSD impact on mental and social functioning

One limitation of Solomon and Mikulincer's study is that it fails to expand on the functional outcome of PTSD worsening and its severity. A more recent study by Fontana and Rosenheck (2010) uses the data produced by Solomon and Mikulincer and expanded on the impact of pre-existing PTSD, especially on social and mental functioning in patients. This study represents an evolution of the research field from the assessment of PTSD (in diagnosis/prognosis), like Solomon's study, to its relevance as a public health issue. By leveraging evidence collected from a database, including the PTSD Status Form (PSF) records of veterans with PTSD collected at specialized VA PTSD programs, this study evaluates parameters of function and mental functionality. Good functionality was established by years of education, being married and employed at time of admission while being separated/divorced and having been incarcerated at sometime during life at the time of admission reflected poor functionality. The mental functionality variables included: PTSD diagnosis, depression, anxiety, or mania, and alcohol or drug abuse. Violence was also included as symptom of a disorder and a behavior representing a major societal problem. Other variables included demographics (age, male gender, white, and ethnicity) and military trauma (receiving hostile or friendly fire, participating in atrocities, witnessing atrocities, sexual trauma, and non-combat trauma).

The study is very complex since it explores the impact of several social and family functioning parameters in managing previous trauma or psychological symptoms. It employs a number of comparisons between the initial causes of PTSD (multiple traumatic episodes, like combat experiences) and behavioral effects (violence, divorce, incarceration, alcohol/drug abuse) to highlight how each of these socio-behavioral parameters can affect the efficacy of the rehabilitation programs.
The authors point the readers' attention specifically to the detrimental impact of alcohol and/or drug use. In particular, doctors and family members face a significant challenge in managing effectively the alcohol/drug abuse. Such challenge represents the main limitation to a successful in reintegrating veterans in family and society. In reviewing the literature, many authors agree that there is a direct correlation between PTSD symptoms and alcohol/drug abuse. Therefore, an effective intervention combining treatment of PTSD symptoms, like depression or anxiety, with family counseling and post-incarceration rehabilitation support may also help mitigate alcohol/drug abuse, increasing the probability of an acceptable societal reintegration.

Social Integration

Undoubtedly, the need to address PTSD in veterans is closely related to understanding the limitations that the disorder poses on social integration, re-entering the workplace, and perhaps more importantly re-establishing family

dynamics and interpersonal equilibrium (Sayer et al, 2014). A study from Julia Sheffler (Sheffler et al., 2016) describes how good marital interactions and a balanced couple relationship is essential in mitigating the impact of PTSD in all aspects of social functioning. This evidence is further supported by a study by Erbes (2012) in U.S. National Guard soldiers from the Iraq war and their loved ones, that analyses systematically, over time, the impact of specific PTSD symptoms like re-experiencing, avoidance, dysphoria, and arousal on the relationship with the partner. The study measures the soldier's perceived improvement or deterioration of the intimate relationship with the partner as compared to the perception collected from the partner at two different points in time. The data is interesting and indicates that the severity of PTSD is a good indicator of the state of the relationship only at the time of the first interview but not subsequently. More importantly, the presence of a specific symptom in the PTSD cluster (dysphoria, or mood swings) can predict that the deterioration of the relationship at both points in time, suggesting that therapies for these mood swings may improve relationship outcomes. The study, however, does not implement the same rigorous approach of the Sheffler's study and falls short of providing better guidance for developing effective couples' therapies. Nevertheless, this study represented a stepping-stone to understand how PTSD can change the dynamic of intimate relationships and encourages researchers to study and establish new paradigms to improve veterans' family life rehabilitation. A very recent study by Freytes (Freytes et al., 2017) analyses all the parameters that are affected in the family life of veterans with PTSD and establishes a correlation between the length of post-deployment and the deterioration of family functioning.

Importance of behavioral intervention

This line of research opened the way to understanding the importance of managing veterans' PTSD effectively to not only stabilize the patient's mental health, but to prevent irreparable disruptions in their quality of life. The evidence presented in this review highlights the importance of reinstating veterans' functionality as a means to prevent family, social, and workplace disruptions.

One of the most relevant studies attesting to the impact of functional rehabilitation of veterans with PTSD is a cornerstone study by Schnurr (Schnurr et al., 2009) on the correlation of PTSD symptoms and quality of life. The study was inspired by a famous question that Dr. Gladis posed in one of his studies: *"Should clinicians and their patients feel that the job is not done (or not done well) if symptoms are alleviated but other areas of the patient's life are not fully satisfied?"* (Gladis et al., 1999, pg 328). Schnurr's study is, to date, the first and only clinical trial designed to systematically evaluate the correlation of changes in symptoms of PTSD over time with changes in functional outcome related to quality of life (including health, self esteem, goals/values, money, work, play, learning, creativity, helping, love, friends,

children, relatives, home, neighborhood, community). PTSD veterans were split in two groups, one receiving trauma-focused group therapy (including psychological support, cognitive restructuring, relapse prevention, and coping skills training), and the other just receiving non-specific group therapy. Veterans demonstrated a significant change in quality of life (24.5% improvement vs 20.7% worsening in QOLI) over time (30 weeks) as well as changes in PTSD symptoms.

This study, however, has two major flaws. Only veterans with an established (consolidated) PTSD clinical symptomatology were included in the trials and the study did not offer information of potential mechanisms leading improvement of the quality of life (perhaps biological, psychological, and behavioral factors may be involved). It is reasonable to believe that veterans with early PTSD symptoms (regardless of their severity) may have responded better to the group therapy and the change in the parameters of quality of life could have been larger and more impactful on veteran's life outcomes. Furthermore, the study only offers a unidirectional look into the correlation of PTSD symptom improvement with positive changes in quality of life. There was no intervention on the quality of life parameters (i.e. couple's therapy, work performance counseling, recreational-engagement approach, etc…) and how such interventions could have improved PTSD symptoms.

Nevertheless, the results of the trial represented the foundation for following studies on PTSD rehabilitation and veterans' reintegration programs.

Therapeutic approach challenges

One of the main problems with the literature evidence is that the majority of the studies are observational and, unlike the study by Fontana and Rosenheck (2010) presented above, don't provide a structured and standardized treatment approach that can work across all PTSD patients. Most of these studies analyzed in a review by Rodriguez (Rodriguez et., 2012), provide a description of record-collection, as shown by the following quote from the author: "*We recommend a multimethod assessment of functional impairment using clinical interviews, self-report instruments, and narratives to collect broad functioning information and information within specific domains. We also suggest that information obtained via patient self-report or clinician rating be supplemented with data from friends, family members, coworkers, supervisors, or teachers to provide a more complete picture of current and premorbid functional status*" (pg 661). Despite acknowledging the importance of establishing an integrated therapeutic approach, the main limitation of the published evidence presented in Rodriguez's review does not provide any

structured guidance on how to develop integrated and consolidated programs to improve social functioning in PTSD veterans.

<u>Rehabilitation and reintegration</u>

Over the last decade a number of studies have looked into the effectiveness of behavioral therapy and alternative therapy (animal, music, reconditioning, etc.) to promote rehabilitation and maintain functionality of veterans with PTSD. A representative study is the one conducted by Woodward (Woodward et al., 2015) on PTSD following non-combat trauma, that showed how the influence of social support, family, friends, and a significant other, can improve PTSD symptoms independently from the type of trauma suffered.

Equally challenging is the reintegration of veterans with PTSD in the workplace. Lack of transportation, inadequate housing, family care burden, and financial burdens are often significant barriers to getting employment and often deter PTSD veterans from rehabilitation and reintegration in the workplace. Lori Davis (Davis et al., 2014) and her colleagues have published a retrospective analysis on the basis of an earlier study that demonstrated a 76% work placement and retention outcome over 1 year for PTSD veterans randomized to the VA Individual Placement and Support (IPS)–supported program as compared to the 8% of those placed in the standard rehabilitation programs offered by the VA. The analysis showed better outcome of the IPS program when transportation, and/or housing support was provided. However, other limiting factors like the family care burden reduced or eliminated the benefit of the IPS program. The study has several limitations, primarily the small size and the retrospective nature of the analysis along with limiting the IPS support primarily to housing and transportation. Nevertheless, this evidence points to the need, along with behavioral and psychological support, for adequate infrastructures and programs tailored to address the initial needs of veterans with PTSD.

<u>"Multimodal" therapeutic approach</u>

It's evident that the challenges faced by veterans with PTSD cannot be managed by addressing the single elements PTSD, as they are all interdependent. The mental illness is the limiting step to any functional and/or social achievement, but a multitude of factors play a 'ripple effect' on dragging veterans with PTSD towards a downward spiral, often ending in suicide or severe psychosis if a consistent support structure is not in place.

In 2005, Drs. Turner, Beidel, and Frueh developed a multicomponent treatment model, called Trauma Management Therapy (TMT), aimed at integrating the psychotherapy program with a behavioral intervention and skill-training component including instruction, modeling, behavior rehearsal, corrective feedback,

positive reinforcement, programmed practice, and flexibility exercises. Although the initial 3-month experimental trial was successful in improving the overall symptomatic presentation and functionality, it is not realistic to expect that three months of intensive behavioral treatment will be useful long-term. Veterans who would benefit from the outcome of the TMT program should uptake this intervention more as a lifestyle modification and a tool to manage their PTSD symptoms (Turner et al., 2005).

In 2011, Dr. Biedel and colleagues published the first randomized controlled trial conducted in male combat veterans with PTSD to compare clinical efficacy of two cognitive-behavioral interventions: Trauma Management Therapy with exposure therapy (TMT), and Exposure Therapy Only (EXP). The study shows significant and meaningful reductions in PTSD symptoms, social and emotional functioning but not on quality of life measures. Furthermore significant reductions in nightmares, flashbacks, and weekly episodes of verbal rage were observed. However, sleep or behavioral avoidance did not change between groups. Interestingly, the TMT group showed increased weekly social activities and greater time spent in weekly social activities (Biedel et al, 2011).

These findings are important as they encouraged doctors and researchers to implement a treatment course that includes many therapeutic options and social support programs. Other research has confirmed that this "multimodal" therapy can improve many social functioning activities as well as anxiety, depression and illness severity. However, many studies still fail to assess the impact of the multimodal treatment approach on other functional domains including marital/family relationships nor employ traditional psychometric measures to assess anger, patient satisfaction, uncontrolled-response behavior.

Conclusions

Managing PTSD in veterans is becoming a pressing public health issue that impacts not only healthcare costs but, more importantly societal interaction. This problem has emerged with greater urgency and renewed awareness following the identification of certain mental health symptoms and behaviors related to PTSD.

PTSD is relatively frequent in veterans, especially in those with conditions like combat stress reaction (CSR) (Solomon and Mikulincer, 2006), and is often the cause of mental and personal challenges for veterans returning from combat (Fontana and Rosenheck, 2010). In addition to a significant impact on health conditions, PTSD has equally important repercussions on veterans' family life and social environment, impacting their quality of life significantly (Schnurr et al., 2009). Veterans with PTSD experience a challenging reintegration into the workplace

(Davis et al,, 2014) and are often unable to re-establish healthy relationships with their life partners and/or children (Erbes et al., 2012). Doctors and experts have tried several types of interventions to mitigate the effects of PTSD across various causes and not only in veterans, without finding a definitive and consistent approach. Not all PTSD patients respond to reintegration programs and, like any other mental health condition, the response to treatments or programs is individualized and requires a multifunctional approach (Beidel et al., 2011).

The overall consensus among sources and writers is that the available data provides a substantive ground for developing standardized veterans' support programs that can be provided to any patient with PTSD as early as at the first appearance of the disorder.

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