

# RESOURCE LINKS

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## ISSUES FACING RETURNING VETERANS



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November, 2007

Dear Colleagues:

These are no ordinary times for the nation and its veterans and those who care for them. For that reason, this issue of Resource Links newsletter is dedicated to understanding the complexities that returning veterans and their families face. This issue, an update to our similar 2004 edition, will focus on the unique as well as the more fundamental issues facing our veterans today.

The rigors of combat in a new era raise new challenges in terms of managing the prevalence of traumatic brain injury (TBI), post traumatic stress disorder (PTSD) and related problems—often compounded by substance use disorders.

For caregivers—professionals and families—those challenges are at once different and the same.

Vets come home to new day-to-day challenges—younger families, tightening economy and job opportunities and the specter of multiple tours of duty. Families—often multi-generations—feel the impact.

For the counselor, the incidence, prevalence, large caseloads and the ever-present issue of finite resources—staff and dollars—are managed by a dedicated but taxed workforce.

It is our hope that this issue will guide the practitioner in the care of veterans as they return to the communities they so selflessly served.

Resource Links is one way that the NeATTC enhances the quality of addiction treatment and recovery services within the region, providing policymakers, providers, consumers and other stakeholders with state-of-the-art information through technology translation and transfer. Visit [www.neattc.org](http://www.neattc.org) for the range of services available to you.

As always, your comments in this continuing dialogue are most welcome at [flahertym@ireta.org](mailto:flahertym@ireta.org)

Michael T. Flaherty, Ph.D.

NeATTC



November 2007

Dear Friends:

At this time each year we pause to remember the men and women who have served in our nation's military. In Veterans Day observances both public and private we show our gratitude and respect for their valor and dedication to duty.

With courageous American troops in harm's way in Afghanistan, Iraq and other parts of the world, we are all reminded of the extraordinary sacrifices that our nation's veterans have made in defense of democracy and freedom. We have a duty to honor those who have served our nation, and as Senator and a member of the Senate Armed Services Committee, I continue to work on ways to show our veterans that we are grateful for their service to our country.

An important issue for service members and veterans is traumatic brain injury (TBI). In 2006, I helped to enact into law major pieces of my *Heroes at Home* legislation to help service members transition home from Iraq and Afghanistan. Specifically, *Heroes at Home* required the establishment of a training curriculum to guide Department of Defense (DoD) and Department of Veterans Affairs (VA) health professionals as they help family members learn to support loved ones suffering from TBI; established a working group to identify ways to help Guardsmen and Reservists transition back to civilian jobs after deployment in Iraq or Afghanistan; and set up a DoD Task Force to assess the mental health challenges – including post-traumatic stress disorder (PTSD) – faced by members of the Guard and Reserve.

This year, I followed up on *Heroes at Home* with a new initiative to better enable the detection of TBI by improving the screening process for our service members; to expand the use of telehealth and telemental health services, which can be particularly helpful to service members and veterans living in rural areas; and to further assist family members taking care of a loved one with TBI by establishing a program that would train and certify them as personal care attendants, enabling them to provide quality care at home while also qualifying for compensation from the VA.

With you, I take great pride in our troops – they are the best that the world has ever seen. I commend the efforts here at home to provide them the reminders that they are both missed and appreciated. I urge you to give our troops your strong support and with me to keep their safety ever in your thoughts and prayers.

Sincerely yours,

Hillary Rodham Clinton  
United States Senator

Dear Friends,

Recently I returned from my third visit to Iraq, where the American troops serving today are carrying on the tradition of service, patriotism, sacrifice, and selflessness that the members of the U.S. Armed Forces have shown throughout our nation's history. As they fight to protect our freedom and liberty, we must ensure that their transition home is as easy as possible.

As a psychologist I've treated more than my share of those who have suffered from significant depression, many of those veterans of various military conflicts. I understand that returning veterans can face the difficulties of post-traumatic stress disorder (PTSD). More than 17 percent of soldiers returning from Iraq will show signs of PTSD, higher than any other military conflict.

We must work better to identify signs of PTSD and treat it among veterans and active duty military. There must be ongoing support and availability of support in combat theaters. Better training for officers in the military is needed so they are aware of signs of problems and treatment options. There also must be access to trained personnel, both while a person is in a combat theater and when they return home and after discharge, because many times the signs of these problems may not show up for years.

Many times soldiers do not seek treatment because they have a fear of being looked down upon by their peers. We must eliminate the stigmas of mental illness and give these soldiers and veterans hope that they can move forward with their lives.

As a nation, we must fully invest in PTSD research in order to gain better knowledge of its causes, symptoms, and treatment. This year the Department of Veterans Affairs received its largest funding increase in history. It includes \$600 million for PTSD care, traumatic brain injury research and care, and \$2.9 billion for mental health care and substance abuse treatment for veterans. It is my hope that these funds will help treat today's returning veterans and research that will be conducted will help those in the future.

Our nation owes a tremendous debt of gratitude to those who have worn our country's uniform and to the families who have stood behind them, both today and in years past. It is vital that we do all we can to ensure they are taken care of after they have done so much to take care of us.

Sincerely,  
Tim Murphy  
Member of Congress (PA-18)

# A CHAPLAIN'S REFLECTIONS ON COMBAT EXPERIENCE OFFERS INSIGHTS INTO RETURNING VETERANS' NEEDS

**“What’s important is that you’ll share a quiet conversation with us.”**

**Douglas A. Etter, CH (LTC) 28 ID “Panther 39”**

**SINCE SEPTEMBER 11, 2001** more than 17,000 of Pennsylvania’s National Guard soldiers and airmen have been deployed as a result of the Global War on Terror (GWOT). Of the 17,000 Pennsylvania Guardsmen and women, who have deployed for the GWOT, more than 5,500 have been involved in direct combat.

I am one of that number.

I served with the 1-110 IN, 2/28 ID under the control of the 2nd Marine Division. We were stationed in the heart of the Al Anbar province 55 miles west of Baghdad in one of the most dangerous places in the world. As you might expect in a high intensity combat environment, inter-service rivalry melted away and we lived, worked, ate, slept, trained and fought together as a cohesive band of brothers, Americans one and all.

We conducted Combat Operations and had contact with the enemy on a daily basis. As a result, we now personally know the thunderous earth shaking of rocket and mortar attacks. We felt the forceful blasts of improvised explosive devices (IEDs). We experienced the single deadly accuracy of enemy snipers and we stood toe-to-toe with enemy combatants in multiple gun battles. The explosive power of rocket propelled grenades (RPGs) was commonplace. Booby traps of all shapes, sorts and sizes were regular discoveries.

Despite all this, we experienced great success. We oversaw two national elections, stood up an Iraqi Army Brigade to whom we turned over battle space, recruited and trained Iraqi police officers, destroyed enemy arms and munitions and neutralized, captured or killed enemy combatants.

Our success did not come without cost.

Overall, our Brigade lost 83 soldiers, sailors and Marines. My battalion lost 15 and awarded 61 Purple Hearts, the military’s award for being wounded by enemy combatants. Some of those wounds were horrific; all of them, I suspect, were life changing.

One of those lost was one of my best friends, LTC Michael McLaughlin from Mercer, PA. He died on a cool

but sunny Thursday afternoon in January when a single pellet from the vest of a suicide bomber struck him in the back of the head. So did about 40 Iraqis applying to become police officers. What the news failed to tell the American public was that after the human carnage was addressed, those Iraqi Police Recruits, more than 1000 of them, got back into line in the hopes of bringing law and order to their land.

“. . .as excited as they were to go home, many were equally afraid. And they don’t know why. It doesn’t make sense, they tell me. They are confused, anxious and embarrassed. They are not sure how they will be received when they get home. They are afraid they won’t fit back into their family or circle of friends. They are nervous about what long-term effects this experience will have on them—physically, emotionally and spiritually.”

For those of us who have tasted it, the experience of combat is unlike anything we knew before or we will experience again. And it’s not simply the fighting, the fear, sweat, blood, smells, noise, exhaustion, strain and pain; it’s also the everyday living.

It was hard. Very hard.

So was the transition home.

- For 18 months I was surrounded by men with guns. When I came home, I felt vulnerable without them, even in church.
- For 18 months, I suffered the indignities and depravities of military life in a combat environment with a core of friends. When I came home I felt lonely without them, even when surrounded by family or other friends.
- For 18 months, I kept a constant watch on my surroundings and the people around me. When I returned home, I could not break the habit but remained hyper vigilant outside the walls of my home.

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- For 18 months, I studied every piece of garbage or discarded junk along the road. When I came home, I couldn't stop. Riding in the passenger seat always made me nervous when someone would drive over a piece of trash.
- For 18 months as a leader of soldiers, I had to keep my emotions in check. When I came home, people told me I was distant and withdrawn.
- For 18 months, I shared common goals and values with others upon whom I depended literally for my life. When I came home, I found dishonesty, hypocrisy and malevolence in people who claimed to be my friends and share common values.
- For 18 months, I had no choice about what to wear, what to eat, what to do or when to sleep. When I came home, I was overwhelmed by choices, sometimes to the point that I was unable to make decisions.
- For 18 months, I dealt with issues that were literally life and death, ones eternal in their scope. When I returned home, I found people worried about matters of no consequence at all.

So let me tell you about what soldiers, sailors, airmen and Marines were worrying about just one month before we came home. These are excerpts from the last letter I wrote home. It has a title, "Quiet Conversations."

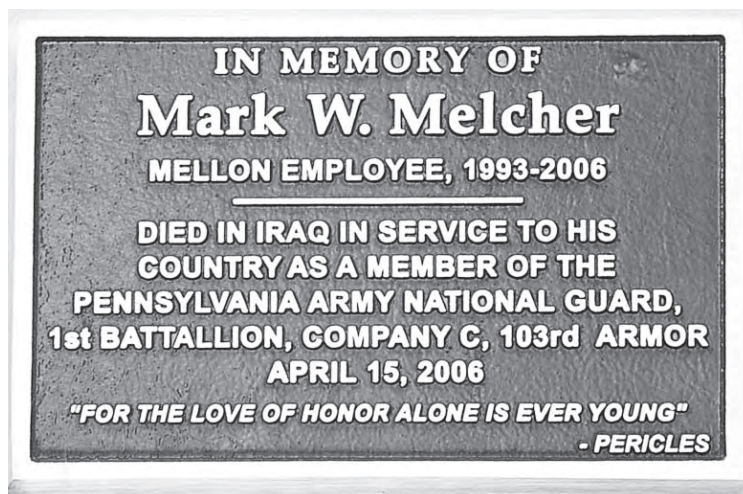
Many times clergy participate in quiet conversations. Sometimes the tones are soft because someone is inviting us into a private space in their being, a place generally reserved for no one but themselves. At other times, the voices are hushed because the person is revealing some past hurt or sin. They may be embarrassed. They may not want to revisit the experience but something inside their soul pushes them to uncover what has been buried for so long.

Some of these conversations are one sided. Sometimes there's no need for me to speak. I must only listen... with my heart as well as my head. At times these conversations center on life's difficult questions. Many are the "why" questions. Or the "how" questions, seeking advice more than answers. And sometimes, all the other may want is to be heard, to be truly heard and understood. Maybe for the first time.

Many of the quiet conversations I am having these days center on the subject of fear or anxiety. The fear is not combat. Most of the soldiers couldn't wait to return home. Yet, as excited as they were to go home, many were equally afraid.

And they don't know why. It doesn't make sense, they tell me. They are confused, anxious and embarrassed. They are not sure how they will be received when they get home. They are afraid they won't fit back into their family or circle of friends. They are nervous about what long-term effects this

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***"My battalion lost 13 soldiers and two Marines. I held some of those boys in my arms as their life slipped away, like SPC Mark Melcher. Mark was a Mellon bank employee who was felled by an enemy sniper's bullet just 28 days after he joined us as a replacement. I kissed him on the forehead after making the sign of the cross there."***

Memorial plaque, Mellon Green, Sixth and Grant Streets, Pittsburgh, Pennsylvania

# AFGHANISTAN AND IRAQ PRESENT MOUNTING NEW CHALLENGES FOR TREATMENT OF VETERANS' SUBSTANCE USE DISORDERS

**Richard T. Suchinsky, M.D., Rockville, MD**

**SUBSTANCE USE DISORDERS** remain one of the most common groups of health disorders among veterans presenting for treatment at the Department of Veterans Affairs medical facilities. Information gathered from other federal general health surveys of the United States population as a whole, which identify veteran status, indicate that significant numbers of veterans with these disorders, or at risk of developing them, do not come to the attention of the Veterans Health Care System. For example, according to the National Survey on Drug Use and Health, 2003 report, a national survey of the general population, an estimated 0.8 percent of veterans received specialty treatment for a substance use disorder (alcohol or illicit drugs) in the past year compared with 0.5 percent of comparable non-veterans. This report may indicate that while veterans seem to be getting specialty treatment for substance use disorders at a slightly higher rate than non-veterans, they may not be receiving care through the Veterans Health Care System. Indeed, we have long been aware that because of eligibility restrictions on access to the federal system, many veterans, if they receive care at all, obtain it through the voluntary or other publicly funded systems.

Those of us who have served in the Veterans Health Care System as well as many outside observers have taken note of the mounting new challenges being presented by the current military actions in Afghanistan and Iraq. The result has been a significant increase in demand to address new health care needs among returning veterans, as well as the prospect of further increases in demand over the next several years as more service men and women return and assume veteran status.

I will present a brief overview of what I believe health care systems in general can anticipate regarding substance use disorders among veterans over the next several years based upon my experience as Chief for Addictive Disorders within the Veterans Health Administration for almost twenty years until my retirement early in 2007.

Among the most critical issues confronting the addiction community in regard to veterans will be the increasing relevance of co-occurring other psychiatric and medical problems in individuals whose presenting complaints may relate primarily to a substance use disorder. The need to

assess patients for such medical and psychiatric conditions will be essential, since often the substance use will be found to be related to such conditions. Successful treatment of the substance use will be contingent on adequate management of the accompanying disorder(s). Already existing data on the prevalence rates of traumatic stress disorders among returning troops strongly suggest that frequent presenting symptomatology will include substance use. Treatment of such substance use requires the integration of treatment for the stress disorder in a coherent fashion.

Of particular interest to voluntary and community based treatment programs is the reality of the combat forces consisting in such large numbers of Reservists and National Guard members. This portends the increasing utilization of community treatment resources rather than VA by those who are employed and have medical insurance.

A related issue concerns the increasing interest and pressure to move the treatment of substance use disorders, especially those identified as "substance abuse" disorders, into the primary care arena. A number of studies have noted success with such undertakings. My observations suggest that such success is dependent on a number of variables: (1) the motivation and experience of the primary care practitioner; (2) the availability of time and scheduling flexibility to the practitioner to allow for time to address unexpected treatment complexities that may arise; and (3) the ready access to specialized substance abuse, psychiatric and psychology consultation and treatment should such be needed.

The challenge of providing adequate substance abuse treatment in rural areas and small communities continues. The VA had made great strides in addressing this problem through its establishment of Community Based Outreach Clinics (COBCs). The challenges still exist, however. My view is that a combination of technology, especially telemedicine, and improved availability of rapid transportation to tertiary care facilities will be the major factors in alleviating these problems.

The impact of past, current and future research on the origins and treatment of substance use disorders offers

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## AFGHANISTAN AND IRAQ PRESENT MOUNTING NEW CHALLENGES FOR TREATMENT (CONT.)

much hope for more specific targeted treatment modalities in the future. We see suggestions of this in currently available pharmacologic agents as well as improved data on the efficacy of various psychological interventions.

Finally, a matter of crucial importance to all who are involved in the treatment of returning combat veterans will be the availability of and willingness to provide appropriate interventions to the families of returning veterans who suffer from substance use problems. The returning veterans are changed by their combat experiences. Their families are similarly changed by the prolonged absences of

spouses and the personality alterations they note among returning family members. I believe this provides the most challenges both professionally and fiscally to those involved in veterans' care. The acknowledged fragmentation and relative disorganization of our systems of care for those with emotional disorders demands our attention.

**Until his retirement in 2007, Dr. Suchinsky was Chief for Addictive Disorders, U.S. Department of Veterans Affairs, for twenty years.**

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## A CHAPLAIN'S REFLECTIONS ON COMBAT (CONT.)

experience will have on them—physically, emotionally and spiritually.

Active duty units return together to the same place and begin training all over again. They are not separated from one another. They live together on a base and continue to socialize and work together. They remain "Army." We, however, who have carried weapons everyday for a year and a half, who have drawn the blood of strangers and who have shed our own... we who have laid in ambush for the enemy, watched him through the grasses and then cut him down so that our homes, families and nation would be safer are now going to be asked to put aside our weapons, our sense of security, to leave one another behind (a thought so repulsive here that it is part of the soldier's creed, "I will never leave a... comrade.") and return to the life of a civilian where most of you have no idea what we have endured or suffered. How could you? What will it be like to be "normal" again. How does one even define normal after all this?

I worry about them. Who will translate for them what has taken place? We still have much to contribute to the world at large. I have not talked to one person who thinks America owes us anything. What we have done, we have done freely and without compulsion. We do not expect reward or recognition.

What we want, what we crave... but what so many may be afraid to say, is your patience, understanding and support. This deployment has been difficult but the readjustment and reintegration into the lives we left behind also will be difficult. Without you, we will not be able to do it. We need your help. We can't do it alone. We are counting on you.

So please, if on some peaceful evening as the sun is melting on the distant horizon or during some fierce afternoon thunderstorm with the rain pouring down and the thunder cracking, if you find us sitting alone, don't be alarmed. If we linger a little while in the pew Sunday morning after the service is over, or if you find us sitting outside in the car alone or in some room in the house... join us. Sit with us. We may say nothing at all... or we may say a great deal, maybe more than you'll want to hear.

But what's important is that you'll share a quiet conversation with us.

You may not have to say anything at all. Your silent presence speaks volumes. It is a language we need to learn anew. It is the language of love.

Thank you for your unwavering support of America's military personnel. And thank you for all you do for our service men and women.

May God bless you and those you love and may God bless America.



# EARLY OR PREVIOUS TRAUMA SUGGESTS PREDISPOSITION FOR POST TRAUMATIC STRESS DISORDER

L. Jeannine Bookhardt-Murray, M.D., AAHIVS, Harlem United Community AIDS Center, NY

## Part I

### THE PREVALENCE OF POST TRAUMATIC STRESS DISORDER

(PTSD) in this country is higher in women than in men, and the highest rate is in women who have served in active military duty and women veterans (Schnurr, Friedman, et al. 2007; Kessler, Sonnega, et al. 1995; Yehuda, 2002). PTSD is associated with histories of exposure to previous trauma, HIV infection and HIV risk behaviors. "HIV vulnerability and the adult survivor of childhood sexual abuse" (Allers, et al. 1993).

HIV infection rates in the military are three to four times higher than in the general population. (Hoge, Castro, et al. 2004; Grieger, Cozza, et al. 2006). PTSD-HIV is associated with histories of sexual abuse and concurrent substance and alcohol use disorders. Breslau, Chilcoat, et al. 1999). PTSD-HIV in women is associated with pre-HIV trauma, greater degree of negative life events, perceived inadequate social support, and greater degree of perceived stigma (Katz, et al. 2005).

Caring for people with the complexities associated with PTSD-HIV requires an intense interdisciplinary team approach. Harlem United Community AIDS Center is located in Manhattan, New York. The Healthcare, Housing, and Prevention Divisions provide programs directed at eliminating disparities and improving community health. HIV special programs for women, women and children, and women with mental illness are available. The agency treats a number of veterans, either primarily or in conjunction with services provided at the local VA Hospitals and Clinics. Harlem United offers a unique HIV Adult Day Health Center (ADHC) in a community environment. Because of the association between trauma, HIV, mental illness and substance/alcohol use disorders the services incorporate care for physical, psychological and social needs. A community of peers in a setting with skilled and caring providers offers "safe space" for trauma victims who often see the world as frightening and unsafe.

A number of ADHC members, including men and women who have served in active duty, have histories of untreated childhood trauma and subsequent trauma. People suffering from PTSD-HIV are reluctant to discuss the traumatic events that have altered their

lives, an obstacle in treatment planning and in establishing trusting relationships. The deep pain, guilt, shame, and anger combined with the stigma of HIV infection is further compounded by substance use disorders and mental illness. These problems lead to sense of loss and hopelessness, often not knowing where to turn for help or whom to trust. The safe space, peer-to-peer support, along with highly individualized health education and healthcare services enables clients to see possibilities for healing and to begin the process. Engendering hope in order to improve physical and mental health is critical to help re-integrate trauma victims into a meaningful and productive life.

Risks for PTSD-HIV include active military service, poverty, urban life, early childhood trauma, medical trauma, substance, alcohol and tobacco use disorders (Schnurr, Friedman, et al. 2007; Kessler, Sonnega, et al. 1995; & Yehuda, 2002).

The case can be made for all primary care providers to screen for previous trauma in order to fully integrate mental health care into medical care. One study reported that 50% of adults and children have been exposed to traumatic events that could lead to PTSD and that up to 50% of those exposed will develop PTSD (Davidson, Bernik, et al. 2005).

Those of us treating adults (including soldiers deployed for active duty and those returning) must be aware of the damaging effects of childhood trauma carried into adulthood. Trauma superimposed upon previous trauma places individuals at greater risk of downward spiral. Routine and systematic screenings for PTSD, co-existing mental disorders, and for tobacco, alcohol, and substance use is necessary to develop effective treatment plans.

It seems however, that we are screening after the fact, when in reality primary care and pre-deployment examinations should aggressively screen for early or previous trauma to better identify those individuals with unresolved psychological problems due to previous trauma which places them at greater risk for deterioration with subsequent trauma.

**PLEASE SEE REFERENCES ON PAGE 15.**

# TRAUMATIC EVENTS ALTER THE LIFE EXPERIENCE

## Part II

### **TRAUMATIC EVENTS SUCH AS WAR AND TERRORISM**

shape existence for individuals in a way that forever alters the life experience. Exposure to a serious injury or life threatening traumatic event associated with extreme fear, horror and helplessness may lead to the development of post traumatic stress disorder. PTSD hallmarks include: re-experiencing a particular traumatic event, flashbacks, nightmares, physiological responses to fear, extreme measures to avoid reminders of the event, overactive startle responses, and detachment from people, surroundings and activities, and internalized trauma (American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 2000).

PTSD can develop immediately after exposure to a traumatic event, or may be delayed for months. PTSD among veterans requires increased recognition among all private, public, civilian, and military healthcare systems and clinicians. According to Dr. Bookhardt-Murray's clinical experience, PTSD's destructive effects include marital/relationship difficulties, abusive home environments, unemployment, homelessness, abuse of substances (including drugs, alcohol and tobacco), and risk of suicide.

PTSD frequently occurs with other mental disorders, such as depression, and is associated with poor health outcomes. The emotional trauma of war and physical injuries compounded by the return to civilian life require a patient centered approach that includes a clinical team, usually composed of social workers, psychotherapists, psychiatrists, and medical providers. Family members and loved ones need support and education so they can be active participants in the care plan.

Social factors, such as lower socioeconomic status, parental neglect, family history of mental illness, lack of support systems, and previous exposure to trauma increase the risks for the development of PTSD. Fifty percent of adults and children have been exposed to traumatic events that could potentially lead to the development of PTSD. Twelve to 50% of those exposed to trauma will develop PTSD. The lifetime prevalence is 8-12% of the population (Davidson, Bernik, M, et al. 2005). About 11.2% to 17% of US veterans returning from active duty in Afghanistan and Iraq, respectively, suffer from PTSD (Hoge, Castro, et al. 2004). The extent of combat related injury is directly related to the development of PTSD over several months. (Hoge, Castro, et al. 2004).

**“Routine and systematic screenings for PTSD, co-existing mental disorders, and for tobacco, alcohol, and substance use are necessary to develop effective treatment plans.”**

Dr. Bookhardt-Murray feels that, on-going research will help to determine why some, but not all, trauma-exposed individuals develop PTSD.

Primary care, emergency department and addiction disorder clinicians may be the first to treat returning veterans. PTSD sufferers may be reluctant to discuss the traumatic event and the effect on their lives. Implementation of systems that will raise awareness and enable non-mental health clinicians to routinely and systematically screen for PTSD are needed.

Immediate intervention with aggressive collaboration among team members enables early stabilization and optimization of treatment. Psychotherapeutic modalities (behavioral, cognitive and eye movement desensitization therapies) and pharmacologic agents (such as serotonin reuptake inhibitors and other antidepressants) are effective. Mood stabilizers, such as carbamazepine and valproic acid are most helpful for impulse control. Alpha-blockers help relieve nightmares. Atypical antipsychotics may benefit patients not responding to other pharmacologic agents. The use of beta-blockers immediately following trauma may diminish or prevent the development of PTSD. Anxiolytics have abuse potential and are generally not effective. The physician must take seriously somatic complaints given the association of PTSD with conditions such as cardiac disease and poor health outcomes.

Once a person has experienced a traumatic life-altering event the world is no longer perceived a safe place. Recreating an environment of hope and safety is crucial to recovery. Reintegration into healthy productive lives and relationships is vital to the troops, their families, loved ones and, ultimately, to our society.

**PLEASE SEE REFERENCES ON PAGE 15.**

### **RESOURCE/TOOL:**

A number of resources and screening tools are available, such as the VA National Center for Clinician Administered PTSD Scale (CAPS) [www.ntis.gov/products/pages/caps.asp](http://www.ntis.gov/products/pages/caps.asp), and NYSDOH AIDS Institute guidelines website [www.hivguidelines.org](http://www.hivguidelines.org).

# CHANGE IN MINDSET BRINGS VETERANS CARE INTO A NEW ERA

**KIRSTEN INGER DANFORTH, CRC, LMHC,** acting program manager of the Albany VA Medical Center’s Chemical Dependency Rehabilitation Program, concurs that the VA offers a variety of levels of care and many more options for today’s veterans.

Kirsten cited preliminary research by Dr. Charles Kennedy that elaborates on the intensity and complexity of cases. He has found that this generation of veterans has been much closer to trauma, has completed or may complete multiple tours of duty, and experience a greater prevalence of mental health issues (40%) and of those upwards of 60% also have an SUD. (VA and Department of Defense Prevalence surveys)

Most of her unit’s clients access services on an outpatient basis. But Kirsten’s unit within the hospital affords a residential option for those who live out of area (the VA in Albany draws from a broad radius) or for a client who may be in an unsafe living environment (e.g., an abusive relationship).

With multiple options under one roof there are distinct advantages in terms of compliance and more effective treatment, she says:

## **CASE CONFERRING:**

This is common, promoting integrated care, particularly critical when dealing with clients presenting with poly-trauma. Rigid protocols are being tempered by “out-of-the-box” thinking. The veteran’s anxiety and nightmares caused by PTSD may require more immediate attention than the SUD. The treatment team can better coordinate timing and levels of care and collaborate on approaches that in the end produce a more effective outcome for the client.

## **RESIDENTIAL INTEGRATION:**

Those receiving care on a residential basis also are able to participate in daytime activities, e.g., manual arts (painting and woodworking).

## **ONE-STOP CONVENIENCE:**

A variety of specialists are available in one location. For example, a client may coordinate counseling, an orthopedic checkup and an SUD support group all at one site.

Kirsten welcomes this flexibility, noting that caregivers and clients alike will benefit from a “change in mindset.” Kirsten says, “We quickly discovered that today’s younger veterans—balancing work and young families—valued evening hours and family sessions.” Often this family session involves parents—likely caregivers for today’s younger veterans.

Kirsten noted that communication also is approached creatively for today’s “instant” generation. “Surveys of clients suggest some preference for email or text messaging for contacts, reminders and follow-up”, she said. “We are much more mindful of environment,” she added. “When we need to paint a unit, we use more inviting, appealing contemporary colors to ‘freshen up’ our look.”

“Today’s practitioners must keep thinking ‘out of the box.’”



# TRAUMATIC BRAIN INJURY

## War on terrorism's "signature" injury calls for support/re-entry programs, employment opportunities, care coordination

**George Zitnay, Ph.D., ABDA, CBIS-CE, Research and Clinical Consultant, Defense and Veterans Brain Injury Center, Department of Defense, Johnstown, PA**

**TRAUMATIC BRAIN INJURY** has been identified as the "signature" injury in the global war on terrorism by the Department of Defense (DOD). Many of us ask, "Why is this happening?" The answer is complex.

First, body armor is more protective than in previous wars; therefore, it saves the lives of persons who in the past would have perished.

Secondly, the availability of immediate care in the field is better than ever.

Thirdly, medics and all personnel are trained to recognize serious injury that must be evacuated to a field hospital. What emerges is a large number of soldiers sustaining brain injuries from explosive devices, from penetrating head injuries and from concussion.

Military blast exposure—principally in the form of roadside improvised explosive devices (IEDs), continues to be the major mechanism of injury for coalition forces in Iraq. In 2005, the U.S. military reported 10,953 IED attacks—an average of 30/day. While the body armor provides significant protection against ballistic penetrating injury, it is unlikely to provide significant protection from the effects of blast overpressure. The ear is the organ that is the most vulnerable to damage by blast overpressure.

According to Dr. Zitnay, in a study of 682 blast injury victims conducted by physicians at Balad Air Force Base in Iraq, of the 541 blast victims who survived, 82% underwent neuro-otologic examination. The overall incidence of tympanic membrane perforation was 35.2%. The overall incidence of loss of consciousness was 35.7%. The study showed a significant association between tympanic membrane perforation and loss of consciousness with concomitant neurologic injury. What this study demonstrates is the need to screen all soldiers exposed to blasts for TBI.

The Defense and Veterans Brain Injury Center (DVBIC), headquartered at Walter Reed Army Medical Center and directed by Colonel Michael Jaffee, M.D., was established by Congress more than 15 years ago to promote "state-of-the-art" treatment for soldiers sustaining brain injury to:

- conduct innovative research aimed at improving outcome from TBI, and
- to develop educational and outreach programs for families of soldiers with TBI

To date, DVBIC and its nine core centers have treated more than 1,800 patients with TBI in post-deployment screening for exposure to blast injury conducted by DVBIC. Of these, 28% tested positive.

While there is no "cure" for TBI, DVBIC and the core members are conducting research to significantly improve outcomes aimed at helping those soldiers with TBI to return to active duty whenever possible or to re-enter the community as contributing members of society.

The military program participants at Laurel Highlands Neuro-Rehabilitation Center (LHNRC), one of the DVBIC core centers, participate in a Community Re-entry Program. Service members are typically several months post injury and have made substantial recovery, yet they still suffer mild to moderate problems from brain injury.

Each soldier who participates in the program at LHNRC stays in a six-bed residential living facility located in a working class neighborhood in Johnstown, Pennsylvania. Designed to be more like a home than a hospital, the residential house provides 24-hour supervision by a trained staff that administer medications, cook meals and provide necessary extended therapeutic support for brain injured service members.

The therapy program is an intensive rehabilitation day program, offering a unique experience of individual and group therapies facilitated by occupational and physical therapists, a neuro-psychologist, speech-language pathologists, and case managers. The program addresses cognitive-behavioral, neuromotor and social skills in a real-world setting while participating in functional, community based activities. Clients work individually and in group settings with therapists to focus on and improve skills necessary for reintegration in the community, return to work, or return to active duty in the military.

The program features therapeutic, educational modules: brain injury education, wellness, empowerment, time management, attention/memory, and social skills. The modules are designed to address difficulties with coping and living successfully with an acquired brain injury.

Some or all of the following skills are developed and implemented in the community: meal planning and preparation, grocery shopping, use of public transportation, increased volunteerism, clubhouse membership, supported

# EROSION OF TODAY'S CORE SOCIAL FABRIC COMPOUNDS RECOVERY AND RE-ENTRY

**THE CAREER SPAN OF CHRISTOPHER R. WILKINS, SR.,** vice president, DePaul Addiction Services, Rochester, gives him a frame of reference that can compare Vietnam era veterans to those in Desert Storm and now the veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

"Terror-based conflict tends to foster the perception of 'no safe place,'" Chris says. "There is a generalized sense of a higher degree of vulnerability."

He cites a higher incidence of PTSD now versus other conflicts (1 in 8) with an apparent relationship between PTSD and substance use disorder. Yet he wonders, "Is it really higher or are we just doing a better job of identifying them?"

Recent veterans from the period of 1993-2007, he feels, have lived through a generation where there has been more erosion of the core social fabric and cultural changes that disrupt social support systems. "They come in (to the armed services) with less, so they come home with less." Chris believes that accounts for an even greater allegiance of soldiers one to another — there is "safety" among those who truly understand.

Chris says, "Families come to us with reports of their loved ones' isolation, moodiness, anger and despondency. They recount that their loved one is 'not the same guy/woman' who went to serve. They look to us to stabilize the person they love." The advantage here is that there is increased incentive to plan with the family on a collaborative basis.

Co-occurring disabilities compound their situations. "A soldier may come home with a head injury and other physical problems and an addiction to manage as well," Chris explains. "Alcohol abuse is most common. It's legal, available, socially 'acceptable' and still changes feelings or alters mood. Yet it poses the riskiest cases due to seizure and cardiac risks."

While today's military face complex medical challenges, so too do they have new reasons for hope. Chris reflects on his dad's post-WWII experience. Chris reflects, "Had he had today's resources, he might have had a better life."

It's too early, he says, to know what the future holds for returning veterans. But Chris knows first hand from his center's partnership with the VA (a first of its kind) that "the caregivers care about how a soldier fares in the VA system."

An approach called a "warm handoff" Chris says, is working very well after four years. Chris has found his VA colleagues (he calls them "pure angels") to be tremendously insightful, looking down the road at what's coming in order to be ready. He offers this example: "We know that there are more women coming in. We are working on building capacity — e.g., hiring a female psychiatrist — to handle that."

All issues related to access and red tape are addressed. "That's the last thing a soldier needs to face after faithful service. Our partnership aims to create a place where the care of those who are wounded, addicted and have a physical illness can all come together."

## TRAUMATIC BRAIN INJURY (CONT.)

work experiences, community navigation, laundry skills, social and communication skills, money management, and medication management. If necessary, prosthetics and adaptive equipment are utilized, all with the goal of developing modified independent living skills.

Recently, Congress approved a significant increase in funding for TBI and post traumatic stress disorder (PTSD). This will result in new treatment methods and improved outcomes and new research aimed at understanding the mechanism of brain injury resulting from blast injuries, and find better protection from blast injury.

While the majority of the injuries are in the mild TBI area, a significant number — upwards of 25% of all brain injuries — fall into the moderate to severe range. Specialized programs for the most severely injured, those in the vegetative and minimally conscious state, are being planned.

It is important to recognize that all of the soldiers who have suffered a brain injury will return home to their communities. Since most of these men and women are coming from small towns and rural areas, we need to prepare the community not just to welcome them home, but to help them readjust to the community, their families and to coping with the stress experienced in the war on terrorism. What are needed are community support groups, employment opportunities, community re-entry programs, and care coordination.

Everyone can help.

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# RESOURCES

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## **PA Guard Mental Health Web Site**

- Provides education and information on a variety of mental health resources.
- [www.dmva.state.pa.us/paarnrg/site/default.asp](http://www.dmva.state.pa.us/paarnrg/site/default.asp)—click on Mental Health

## **Military Mental Health Self-Assessment**

Free private and confidential online and phone mental health self-assessment for:

- Depression, Post Traumatic Stress Disorder, Anxiety Disorder, Bipolar Disorder and Alcohol Abuse
- Available 24/7 at [www.MilitaryMentalHealth.org](http://www.MilitaryMentalHealth.org)
- Provides immediate feedback and referral information on TRICARE, Vet Centers, Military One Source, and Deployment Health for family members and service personnel affected by deployment and mobilization.
- Online and phone self-assessment approach intended to help families and service members identify their symptoms and obtain assistance.
- Toll-free Self-Assessment—1-877-877-3647

## **Veterans Affairs (VA)**

- Free medical and mental health care for two years after discharge from active duty for conditions possibly related to your combat theatre service, regardless of your income status. After two years, VA services continue to be available for eligible individuals. Co-pays are then based on income.
- PA VA network consists of 9 Medical Centers, 36 Community Based Outpatient Clinics, 8 Vet Centers, and a PTSD program—[www.va.gov](http://www.va.gov).
- VA also has specialized health and counseling services for women who served. Contact information for Women Veteran Program Managers—[www1.va.gov/womenvet/](http://www1.va.gov/womenvet/)
- General information number for VA questions: 1-877-222-VETS.
- Vet Center Readjustment Counseling [www.va.gov/rcs/](http://www.va.gov/rcs/).

## **TRICARE Behavioral Health Plan**

- Soldiers and their families are eligible for six months of mental health care after discharge from active duty.
- Recorded mental health information: “Audio Health Library” 24 hours a day, 7 days a week.
- [www.tricare.osd.mil/](http://www.tricare.osd.mil/) or phone 1-877-TRICARE (1-877-874-2273)

## **Military One Source**

- 24 hour, 7 days per week Information and Referral service for National Guard soldiers and their families. Private and confidential.
- Services include interactive web site, educational materials, research on issues and resources, and referrals to match specific needs.
- No cost to service member or family.

- Short term face-to-face counseling by licensed professional in your community (up to six sessions per person per issue).
- Services also available for six-months after discharge from the Guard.
- [www.militarysource.com](http://www.militarysource.com) or phone 800-342-9647

## **Troop & Family Counseling Services for National Guard & Reserves**

- 1-888-755-9355 / 24-hour, 7 days per week year-round free access. Private and confidential.
- Counseling professionals include social workers, marriage and family counselors, psychologists, and child and youth counselors.
- Soldier and family are entitled to six prepaid face-to-face counseling sessions for issues related to marriage/relationship, family, stress and anxiety, depression, grief and loss, anger management, and parent/child communication.
- No cost to service member or family.
- Services also available up to six-months after discharge from the Guard

## **Employee Assistance Program**

- Covers Technicians & Active Guard Reserve (family members included).
- Confidential and private counseling service
- 24 hours a day, 7 days a week access.
- Short term counseling (six sessions).
- No cost to service member or family.
- [www.foh.dhhs.gov](http://www.foh.dhhs.gov) or phone 1-800-222-0364

## **Post Deployment Health Reassessment (PDHRA)**

- Purpose is to identify deployment related mental health concerns and make appropriate referrals.
- Conducted 3-6 months after return from deployment. Also addresses health concerns.
- Contact unit to schedule
- [www.fhp.osd.mil/pdhrainfo/index.jsp](http://www.fhp.osd.mil/pdhrainfo/index.jsp)

## **Walter Reed Medical Center Deployment Health Clinical Center for Specialized Care Program (SCP)**

- For service members experiencing difficulties re-adjusting to life after service in OEF/OIF. Also for individuals who have had other treatments for PTSD (or depression), but continue to experience symptoms that interfere with their functioning.
- Members of the National Guard and Reserves must be on active orders at the time of evaluation and to participate in the program. Evaluations are on a referral-only basis. Participation in the 3-week Outpatient SCP is based on acceptance following the evaluation.
- See web site for guidelines on initiating the referral process and for program content [www.pdhealth.mil](http://www.pdhealth.mil)
- For further information call 202-782-6563 or e-mail Karen.Friedman@na.amedd.army.mil

## **Chaplain Services**

- Trained in dealing with deployment and reintegration issues.
- Conduct “Relationship Enhancement Program” for married couples who have gone through deployment or are anticipating deployment. Call 1-800-634-1790, option 1, to register.

- Trained in suicide prevention skills and critical incident stress management.
- Full-time Support Chaplain 717-861-9212, cell 717-821-6050.

### Battle Mind Training

- Assists soldiers & families with making the transition from the combat zone to the home zone.
- Addresses pre-deployment, deployment and reintegration issues.
- Site contains power points, brochures, and a Battle Mind Training video.
- [www.Battlemind.org](http://www.Battlemind.org)

### Suicide Prevention

- If having suicidal thoughts contact county Crisis Intervention or report to the nearest Emergency Room
- Or call 1-800-273-TALK (8255). Available 24 hours per day, 7 days per week
- National Guard Suicide Prevention web site—  
[www.virtualarmory.com/WellBeing/suicide.aspx](http://www.virtualarmory.com/WellBeing/suicide.aspx)

### Community

- Employer medical benefits, human service agencies, college counseling programs
- For additional information or assistance contact CPT James Joppy, MSW, 717-903-7657 or 717-861-2769, Fax 717-861-2637 e-mail: [James.Joppy@us.army.mil](mailto:James.Joppy@us.army.mil)

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### 3 QUESTION DVBC TBI SCREENING TOOL

**1. Did you have any injury(ies) during your deployment from any of the following?**

(check all that apply):

- A. Fragment
- B. Bullet
- C. Vehicular (any type of vehicle, including airplane)
- D. Fall
- E. Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
- F. Other specify: \_\_\_\_\_

**2. Did any injury received while you were deployed result in any of the following?**

(check all that apply):

- A. Being dazed, confused or "seeing stars"  
NOTE: Endorsement of A-E meets criteria for positive TBI Screen
- B. Not remembering the injury
- C. Losing consciousness (knocked out) for less than a minute
- D. Losing consciousness for 1-20 minutes
- E. Losing consciousness for longer than 20 minutes
- F. Having any symptoms of concussion afterward  
NOTE: Confirm F and G through clinical interview (such as headache, dizziness, irritability, etc.)
- G. Head Injury
- H. None of the above

**3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion?**

(check all that apply):

- A. Headaches
- B. Dizziness
- C. Memory problems
- D. Balance problems
- E. Ringing in the ears
- F. Irritability
- G. Sleep problems
- H. Other specify: \_\_\_\_\_

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66(5)(Supp. 2), A235.

### 2 Continuing Education Hours for \$20

You are eligible to receive (2) Continuing Education (C.E.) credits by completing a post-test based on this issue of the *Resource Links*. Return the completed post-test and a \$20 check for processing fee to the Institute for Research, Education and Training in Addictions (IRETA). Please make check payable to IRETA. A passing grade for the post-test is 80%. Applicants that receive an 80% or above will receive a certificate by return mail stating that he/she has been awarded 2 CEs. Credits are issued by the National Association for Addiction Professionals (NAADAC).

## — REGISTRATION FORM —

### ISSUES FACING RETURNING VETERANS

NAME AND DEGREE AS YOU WISH THEM TO APPEAR ON YOUR CERTIFICATE (PLEASE PRINT):

NAME: \_\_\_\_\_ DEGREE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

I confirm that I personally have completed the above test, and I am submitting it for evaluation and certification.

SIGNATURE: \_\_\_\_\_ DATE COMPLETED: \_\_\_\_\_

Evaluation: Overall, this issue of *Resource Links* (circle appropriate response)

PROVIDED INFORMATIVE UPDATES	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	WAS NOT INFORMATIVE
EXPANDED MY KNOWLEDGE	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	DID NOT EXPAND MY KNOWLEDGE
PROVIDED USEFUL RESOURCES	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	DID NOT PROVIDE USEFUL RESOURCES
WAS APPROPRIATE FOR MY TRAINING LEVEL	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	WAS NOT APPROPRIATE



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and Training in Addictions

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## ISSUES FACING RETURNING VETERANS

# POST-TEST

You are eligible to receive two (2) Continuing Education (CE) credits by completing this quiz based on this issue of *Resource Links*. INSTRUCTIONS: Indicate the best answer to each of the following questions and return the completed test and application form (on back) with a check for \$20 to The Institute for Research, Education and Training in Addictions.

1. **What disorder remains one of the most common groups of health disorders among veterans?**
  - a. Substance use disorders
  - b. Psychiatric disorders
  - c. Cardiac disorders
  - d. None of the above
  
2. **The prevalence of post-traumatic stress disorder (PTSD) in this country is higher in women than in men, and the highest rate is in women who have served in active military duty and women veterans.**

True    False
  
3. **PTSD is associated with histories of exposure to:**
  - a. Drugs and alcohol
  - b. Nightmares
  - c. Previous trauma
  - d. None of the above
  
4. **HIV infection rates in the military are three to four times higher than in the general population.**

True    False
  
5. **PTSD-HIV is associated with:**
  - a. No associations with previous history of sexual abuse
  - b. Histories of sexual abuse and concurrent substance and alcohol use disorders
  - c. History of cancer in the family
  - d. None of the above
  
6. **In treating PTSD it is recommended that immediate intervention with aggressive collaboration among team members enables early stabilization and optimization of treatment.**

True    False
  
7. **Which of the following has been identified as the “signature” injury in the global war on terrorism by the Department of Defense (DOD).**
  - a. Post traumatic stress disorders
  - b. Psychiatric disorders
  - c. Behavioral disorders
  - d. Traumatic Brain Injury
  
8. **Military blast exposure-principally in the form of roadside improvised explosive devices (IEDs), continues to be the minor mechanism of injury for coalition forces in Iraq.**

True    False
  
9. **Which of the following provides significant protection against ballistic penetrating injury, but is unlikely to provide significant protection from the effects of blast overpressure.**
  - a. Shields
  - b. Body armor
  - c. Both a & b
  - d. None of the above
  
10. **Recently, Congress approved a significant increase in funding for TBI and Post Traumatic Stress Disorder (PTSD).**

True    False



## 3 QUESTION DVBIC TBI SCREENING TOOL INSTRUCTION SHEET

### Purpose & Use of the DVBIC 3 Question TBI Screen

The purpose of this screen is to identify service members who may need further evaluation for mild traumatic brain injury (MTBI).

### Tool Development

The 3 Question DVBIC TBI Screening Tool, also called The Brief Traumatic Brain Injury Screen (BTBIS), was validated in a small, initial study conducted with active duty service members who served in Iraq/Afghanistan between January 2004 and January 2005.

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66(5)(Supp. 2), A235.

### Who to Screen

Screen should be used with service members who were injured during combat operations, training missions or other activities.

### Screening Instructions

#### QUESTION 1:

A checked response to any item A through F verifies injury.

#### QUESTION 2:

A checked response to A-E meets criteria for a positive screen. Further interview is indicated. A positive response to F or G does not indicate a positive screen, but should be further evaluated in a clinical interview.

#### QUESTION 3:

Endorsement of any item A-H verifies current symptoms which may be related to an MTBI if the screening and interview process determines a MTBI occurred.

### Significance of Positive Screen

A service member who endorses an injury (Question 1), as well as an alteration of consciousness (Question 2 A-E), should be further evaluated via clinical interview because he/she is more highly suspect for having sustained an MTBI or concussion. The MTBI screen alone does not provide diagnosis of MTBI. A clinical interview is required.

[www.DVBIC.org](http://www.DVBIC.org)

1-800-870-9244