The Invisible Wounds of War

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Editor's Note: This editorial was written by John A. Renner, Jr., MD, CAS. Dr. Renner is Professor of Psychiatry, Boston University School of Medicine and Associate Chief of Psychiatry, VA Boston Healthcare System. We are grateful to Dr. Renner for sharing his insights regarding the treatment of veterans for a range of post-deployment conditions, including substance use disorder.

After 9/11 they signed up in droves – young men and women from the inner cities, the suburbs and the heart land. Most were driven by a strong sense of patriotism and duty. There was no need for a draft – unlike Vietnam, the US became engaged in a major conflict with a fully volunteer military force. Many left behind young families and promising careers, others walked away from bleak futures with little promise. We now know that many hid histories of prior psychiatric difficulties and problems with substance abuse in their zeal to be accepted by the military. As with any war, there were many individuals looking for a second chance – challenged by the demands of adolescence, they were looking for fresh start, an opportunity to prove themselves or to find the discipline and structure they needed to ease the path into adulthood.

The realities of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) were very difficult for most of our troops. There was no quick and decisive victory. Stress levels were high and the enemy proved cunning and elusive. This was a war in which the threat of death or injury was ever present and there were no safe areas in the rear. Nonetheless, most of our troops returned with a strong sense of self-confidence; their faith in their band of brothers (and sisters) was powerful and sustaining. Equally strong was a military ethic that valued toughness and reliability above all of virtues and abhorred signs of weakness.

There were many ways in which this conflict was unique. Injuries caused by IED's led to amputations and other types of severe trauma; powerful explosives and associated shock waves resulted in a much higher incidence of traumatic brain injuries (TBI's) (over 30% of troops in some estimates). Superb acute care and sophisticated rehabilitation services meant that many individuals survived wounds that would have been fatal in previous wars. The availability of more potent, long-acting opiates meant better control of pain – both in combat and in

the civilian world, physicians were strongly encouraged to be more aggressive in the use of these new medications. Unfortunately, prescribing patterns that were therapeutic in acute settings proved problematic when used for chronic pain. In addition, soldiers with lesser complaints, anything from low back pain to headaches, found it easy to obtain opiates and easy to stay on duty despite their pain.

The signature wounds of OIF/OEF have been identified as a triad composed of PTSD, TBI and chronic pain syndromes. The high incidence of PTSD is directly related to the chronic severe stress levels experienced by most our troops and to their repeated tours of duty. Similarly, chronic pain syndromes are not unusual among injured soldiers. TBIs are also common both in soldiers with physical injuries and in those with PTSD. In one sample of 340 OEF/OIF veterans evaluated by the VA, 81.5% had chronic pain, 68.2% had PTSD and 66.8% had TBI. The majority of these combat veterans presented with more than one condition and 42.1% presented with all three conditions.[1] In 2013, the VA reported that 27.5% of veterans with a substance use disorder also had PTSD. There is another dynamic at play within this clinical arena. It is not unusual that individuals with chronic pain and/or TBI have been prescribed opiates. Many soldiers instantly recognize that these prescribed opiates dramatically reduce the depression and anxiety and other symptoms associated with their PTSD. Clinicians have long recognized the rapidity with which many individuals with PTSD develop an alcohol use disorder in an effort to self-medicate their symptoms. We now understand that soldiers with PTSD may find that opiates are less obviously disruptive than alcohol and easy to obtain when you request medication to treat a combat injury. Addiction treatment providers are now seeing a signature constellation of four disorders in these returning veterans: PTSD, chronic pain, TBI and Substance Use Disorders. Whether veterans present with an opiate use disorder, an alcohol use disorder or a combination of the two, these veterans commonly present with multiple other medical and psychiatric problems.

Unfortunately many of these veterans have been reluctant to seek treatment. Admitting to symptoms of PTSD is thought to be a major impediment for any soldier planning a career in the military. Self-medicating with alcohol or pain killers is seen as more acceptable and more consistent with the “tough guy” military image. The end result may be an addiction that rapidly spirals out of

control and destroys any chance for a military career. Those with more obvious physical injuries may fare better. The problems may be more apparent to those around them and asking for help may be less of a psychological risk. There has been a significant shift in attitude within the military and unit commanders, who now promote the benefits of self-referral and seeking treatment. It is anticipated that these changes will reduce the morbidity of PTSD and associated substance use disorders and will promote retention among active duty troops.

Significant problems remain addressing the needs of those veterans who have returned home. We should all be concerned about those individuals with the more invisible wounds of war: PTSD, TBI, substance use disorders and those whose physical injuries that may not be as visible to others. Where do we see them today? Walking the streets, homeless, unemployed? In many cities, the majority of single homeless men are combat veterans. Many others are still functioning in the community, but mask their physical and psychological pain with alcohol and pills. They have paid a high price for their patriotism and sense of duty. Unfortunately, their self-image as a "tough guy" soldier may impede their reaching out for needed help. Upon discharge, the sudden loss of the strong support system provided by the military led many soldiers to regress back to early dysfunctional patterns of behavior.

The VA has developed many new and creative programs to address the needs of the returning veterans. Unlike the Vietnam era veterans who were more alienated from the system and often avoided treatment until their addictions had become much more severe, the OEF/OIF veterans have generally entered treatment at an earlier and more manageable phase in their illness. It has been a privilege to work with these young veterans and very encouraging seeing how many have quickly responded to treatment. The availability of addiction pharmacotherapy, a full range of residential rehabilitation programs and housing, vocational and educational benefits, has made the job much easier. Nonetheless, the help and support of community clinicians is needed to identify those veterans who are still in need of treatment and to facilitate their connection to available resources. This BASIS Special Series highlights the broad range of addiction problems seen in these veterans, from gambling and nicotine to the alcohol and other drugs. It brings home the complexity of managing these problems when they co-occur with PTSD and TBI. Clinicians will find this is a very useful introduction to a highly gratifying area of practice.

Need help? Veterans can access a variety of resources for dealing with mental health issues here.

– John A. Renner, Jr., MD, CAS, Professor of Psychiatry, Boston University School of Medicine; Associate Chief of Psychiatry, VA Boston Healthcare System. This editorial reflects Dr. Renner's personal views, not those of the Department of Veterans Affairs.

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[1] Lew, H.L., Otis, J.D., Tun, C., et al. (2009). Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: Polytrauma clinical triad. Journal of Rehabilitation Research & Development, 46(6), 697-702. Click here for this article.