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A Practical Approach to Military PTSD

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It's time to commit to programs that will serve our troops with the same fidelity with which they serve us.

Goran Tomasevic/Reuters

Since 2001, more United States troops have died from suicide than have been killed in Afghanistan. The Army estimates that up to 20 percent of those deployed in Iraq and Afghanistan -- half a million men and women -- will suffer the disabling agitation, nightmares, and emotional withdrawal that characterize post traumatic stress. Military leaders, the Secretary of Defense, the President, and Congress speak of the gravity of the problem and the inadequacy of present approaches to care.

Post-traumatic stress disorder is not new. 2,500 years ago Herodotus described soldiers at Thermopylae who were filled with shame and guilt, trembling, unable to fight. In conflicts from the Civil War on, extreme psychological distress has been noted in a significant percentage of combatants: well over a million, for example, in World War II, and 500,000 out of the 2.8 million who served in Vietnam. It was not, however, until 1980 that the American Psychiatric Association's third edition of its *Diagnostic and Statistical Manual* named the condition "post-traumatic stress disorder" and brought it widespread recognition.

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Though the suicide rate now is significantly higher than it was in pervious conflicts, and the deaths from combat, lower, it is not clear that the overall incidence of conditions we now call PTSD and major depression is actually greater. While the situation is indeed grave now, it appears to have been equally serious, if less widely acknowledged and publicized, in earlier conflicts. It is time for thoughtful attention to contribute to improved outcomes.

The primary answers recently proposed by experts at the Department of Defense and the Institute of Medicine -- better screening for depression, suicidality, and PTSD, better integration of clinical services, and more mental health professionals and preventive programs -- are reasonable. Unfortunately, they are likely to make little difference in the numbers of men and women who die from suicide and are disabled by psychological distress, and equally important, to the numbers who actually use the services offered. In fact, the focus on diagnosis and treatment may continue to alienate those it is supposed to serve and perpetuate the problem rather than offer a viable solution.

My 15 years of experience creating programs of population-wide psychological healing in war, post-war, and post-disaster situations (in Kosovo, Israel, Gaza, Haiti, and southern Louisiana) and seven years with the U.S. military and the VA strongly suggest to me the need for fundamental change. Non-stigmatizing educational approaches grounded in self-care and mutual help, which are being piloted in programs in the military and the VA, including the one we at the Center for Mind-Body Medicine, use, are more appealing to troops and their families, and more likely to provide the relief they need, as well as the renewed sense of hope and meaning they crave. They need to be moved from the periphery of services offered to the very center of our approach to the problems the military faces.

What follows are principles that are critical to our work with the military -- principles that, in various combinations, are beginning to shape a variety of other programs which are significantly more appealing to and beneficial for our military and their families.

Make psychological services universally available -- and compulsory. "Going to the shrink" is, for most military, personally embarrassing, socially stigmatizing, and potentially lethal to career advancement. If, like basic training, a program of self-care were required of everyone, unease at self-disclosure would become a rite of passage and stigma and career damage would cease. Previous efforts to provide pre-deployment resiliency training, though well intentioned, have not lived up to their promise, largely because they have not been guided by the principles below.

Personalize care. This means personal for the caregiver as well as the one coming for help. When the 350 clinicians whom we've trained talk to active duty and veterans, they don't say, "You've got a problem and this is the appropriate treatment." This creates distance and many feel demeaned by it. They say instead, "This changed my life. I do this meditation and use guided mental imagery and even shake and dance to relieve my stress, every day. Are you interested?" They are inviting and sharing, not prescribing. Many troops who would never go to other therapies or who have dropped out of treatment feel welcomed and curious, and sign up.

Work with the body and the mind. People who have been psychologically traumatized are agitated in both mind and body; those who are depressed are physically as well as mentally depleted. Movement can help break up these fixed physical and emotional patterns and activate those immobilized by despair. Aerobic exercise, for example, has repeatedly been shown to be as effective for depression as anti-depressant drugs or psychotherapy. The DoD and VA are beginning to recognize the importance of therapies that address the body -- studies on yoga and martial arts are underway -- but including movement in all approaches should be the rule, not the exception.

Make group therapy standard. This is partly a matter of economy. No matter how many mental health professionals are hired there will never be individual therapy for all. But there are also advantages to groups. For many, individual sessions with a mental health professional are unpleasant and demeaning. "I felt like a bug under a microscope," is a sentence I've often heard from veterans. Groups -- especially ones where sharing is central and where interruption, analysis, and interpretation are forbidden -- take the embarrassing spotlight off individual speech and behavior. Members are all in it together and so is the leader, who often does the self-care exercises along with them and shares his or her experience and feelings. Small groups which can be led by trained peers as well as professionals are also familiar and supportive. They are the way troops are organized in the military. Groups should be routine, individual approaches the exception.

And groups can yield results that are at least as good as individual therapies. Research on the Center for Mind and Body Medicine group model, published in peer-reviewed journals, shows an 80 to 90 percent improvement in PTSD symptoms in war-traumatized populations, along with significant elevations in mood and a lifting of the sense of hopelessness. The results were largely maintained, in spite of ongoing armed conflict and severe economic stress, at seven months follow-up (in Gaza). A Department of Defense (DoD) funded randomized controlled trial of our program with war-traumatized US veterans, still in progress, also looks promising. Even more important, this approach -- and similar ones which emphasize self-care and mutual help -- appeals to large numbers of people, including military, who have been dissatisfied with or refused to seek out conventional mental health care or who do not have access to it.

Focus on the practical. Military people are generally can-do types. They like to learn and use skills and to see results -- quickly if possible. Yoga postures improve flexibility and restore confidence. Slow deep breathing lowers heart rate, relaxes tense muscles, and, for many, quickly leads to better sleep. Simple biofeedback devices show troops that they can use their mind to warm hands chilled by stress. Guided imagery and drawings mobilize their imagination to provide answers to previously insoluble problems.

Appreciate strength and encourage, but don't force, vulnerability. Every group should be a place where each member can share his or her successes in dealing with challenges. At the same time, a regular and unforced check-in process allows every member to talk about pain that persists and difficulties doing self-care techniques. Some military appreciate and benefit from therapies that focus on traumatic events; most want to deal with them when and if they are ready.

Introduce a wide variety of techniques. The recent Congressionally mandated Institute of Medicine report, among other studies, suggests that combining different approaches produces better results than offering them singly: for example, using strategies for changing patterns of thought together with techniques that release emotions. We've found that teaching a number of forms of self-awareness and self-care, and allowing each person to experiment and decide which ones are most effective for him, honors individual differences and maximizes results. Similar approaches combining self-care with more conventional therapies are being warmly received and successfully used at the new National Intrepid Center of Excellence for PTSD and Traumatic Brain Injury, at Bethesda Naval Hospital, and at Fort Bliss, Fort Hood, and Landstuhl Hospital in Germany, as well as at many VAs.

Keep everything out of the permanent record. Half of all active duty and veterans diagnosed with PTSD and major depression do not go to therapy at all. And many who do are quite cautious about what they share. In one of our mind-body groups in a mid-Western state, three out of ten veterans were seriously suicidal, and one was homicidal. All were regular VA patients. Before our group, none had shared their grim plans or the terror and guilt their feelings and intentions had evoked. In time, in a group where any records were shielded from the system and where anger and terror were not met with fear, censure, or pharmaceutical "treatment," all felt free to speak. By the end of ten weeks, all were feeling significant relief and none felt compelled to act on what they had finally shared.

These principles can help reshape programs that are already being offered and provide a framework for new ones throughout the VA and military systems. It's time to stop offering treatments that serve our troops poorly and that many do not want. We need to let go of received clinical ideas and commit to developing programs that our military will actually use, to serve them with the same fidelity with which they have served us.