Empowering Veterans Towards Healing

Nadia McDonald

Tallahassee Community College

PSY 100 Introduction to Psychology

Professor Schaberg

October 11, 2016
Empowering Veterans Towards Healing

“Whatever came off that plane to me was a monster. I’m supposed to be a rock, and there’s nowhere to turn,” reported the wife of a National Guardsman who returned from war with a completely altered personality (Kime, 2013, para. 24). The woman, who wished to remain anonymous, was unable to receive adequate, convenient care for her husband (Kime, 2013). Not all returning veterans’ cases are as hopeless. At the opposite end of the spectrum, former Marine Yusra Kaupilla successfully controlled her post traumatic stress disorder (PTSD) symptoms through yoga and meditation (Kwan, 2015). The key difference between these two veterans is that one received the help and resources she needed to regain control of her identity, her life, and her future. Many veterans who return from war are not as fortunate as Kaupilla because they are disempowered and debilitated by PTSD. The United States Department of Veterans Affairs estimated that 11-20% of veterans from Operation Iraqi Freedom and Enduring Freedom suffer from PTSD (Department of Veterans Affairs/National Center for PTSD [DV A/NCPTSD], 2015b). Even though a large number of veterans have this disorder, many soldiers discover that getting this diagnosis is an exasperating endeavor. Finding a successful treatment plan for this disorder is even more difficult than obtaining the official diagnosis (Hoge, 2010).

Veterans are often at the mercy of a hierarchy that forces PTSD sufferers to use specific evidence-based treatment modalities that are often ineffective at reducing PTSD symptoms (Paulson & Krippner, 2007). A soldier’s place on this hierarchy is constrained by the United States Armed Forces’ “leader-follower” power structure. In Turn the Ship Around: A True Story of Turning Followers into Leaders (2012), L. David Marquet argued that the “leader-follower” dynamic of armed forces does not empower the “followers” (those low on the proverbial totem pole) or allow them to maximize their individual capabilities. In fact, the leader-follower
dynamic actually disempowers soldiers since they lack direct agency over their circumstances. Marquet suggested that a “leader-leader” dynamic, where power and control are distributed throughout an organization instead of from above, empowers individuals to act with authority and exercise control over their environments. The Veterans Administration (VA) and its medical personnel should adopt a "leader-leader" dynamic for the treatment of PTSD by allowing veterans access to a diverse array of treatment options from which they may select the modalities that work best for them as individuals. Empowerment, in this case, means veterans having access to their preferred treatment options at any VA Medical Center in the United States. Veterans who receive self-directed, individualized treatment stand the best chance of managing, and hopefully recovering from, PTSD principally because they will have control over the recovery process (American Legion TBI/PTSD Ad Hoc Committee [ALAHC], 2013).

**Causes and Symptomology of PTSD**

An improvised explosive device (IED) explodes, a soldier falls, a car crashes, or an unfathomable loss occurs. All those who suffer from PTSD have an event, or series of events, that precipitate and are the defining trauma of the disorder. Finley (2011) commented that this is “in essence what post-traumatic stress disorder means: an event occurs that led to psychological, physiological, and emotional disorder” (p. 23). While some veterans experience a singular traumatic event that causes PTSD, the traumatic childhoods and circumstances of others contribute to their PTSD. For these sufferers, past traumas are the kindling that helps ignite the clinical disorder (Paulson & Krippner, 2007). The presence of this trauma is usually necessary for PTSD to develop because a singular traumatic event does not often cause PTSD (Finley, 2011). Paulson and Krippner (2007) argued that veterans experience PTSD on a continuum of severity: there are those who receive an official diagnosis, others who may be “subclinical,” and
EMPOWERING VETERANS

those who have not received an official diagnosis or recommendation for help. Comorbidity of PTSD to other disorders is another issue that complicates diagnosis and treatment. Many veterans suffer from mental disorders such as depression (23.2%) and anxiety (20.7%) that may be comorbid with clinical or subclinical PTSD (Puetz, Youngstedt, & Herring, 2015).

The symptoms of PTSD are physiological in origin and affect despite the fact that psychiatrists classify PTSD as a mental disorder. Hoge (2010) suggested that the study of PTSD is, in actuality, the study of “stress physiology” (p. 2). Jeffreys explained that:

PTSD can be conceptualized as a dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and the balance between excitatory and inhibitory brain neurocircuitry. There is a resultant dysregulation of adrenergic mechanisms that mediate the classical fight-flight or freeze response. (2014, para. 5)

Clinically speaking, all victims of PTSD share a common symptomology and meet eight diagnostic criteria as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) V. In order to receive a diagnosis, the person first must have suffered exposure to a stressor, or defining traumatic event, that precipitated the disorder (American Psychological Association [APA], 2013). The American Psychological Association also noted that one must experience “symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity” (as cited in DVA/NCPTSD, 2015a, para. 3). The person seeking diagnosis must also experience these symptoms for at least a month according to the sixth criterion, and, in order to meet the seventh criterion, these symptoms must negatively impact his or her life (APA, 2013). Finally, the eighth criterion is that this “disturbance is not due to medication, substance abuse, or other illness” (as

In-text citation format for three to five authors.

Block quote.

Note: If the author, year, or page number is included in the narrative, you do not have to include it in the citation.
cited in DVA/NCPTSD, 2015a, para. 9). A veteran seeking a diagnosis must meet all of the above criteria in order to receive an official diagnosis of PTSD.

Despite the fact that PTSD is a clinical diagnosis with specific, categorical symptoms listed in the DSM, it may affect veterans in variety of ways that transcend the official diagnosis. A 2012 study conducted on Danish soldiers indicated that the development of PTSD symptoms demonstrated “heterogeneity,” which points to the “need for multiple measurements to understand PTSD and identify people in need of treatment” (Bernsten et al., p. 1557). While one veteran’s case appears “textbook,” another’s may be atypical in its presentation (Finley, 2011, pp. 49-50). The documentary, That Which I Love Destroys Me, chronicles the post-military lives of Special Operations (Ops) veterans Tyler Grey and Jayson Floyd. Both Grey and Floyd suffer from PTSD, yet the condition’s primary symptom manifested differently in these men. Although both men pushed away people, Floyd, unlike Grey, experienced bouts of rage, problems with impulse control, and a year of homelessness. Both men were able to heal with different treatments: while Floyd was helped by a psychologist, Grey derived the most benefit from participating in a challenge called “The American Heroes Challenge” (Waugh, 2015). There is no single treatment for PTSD that works for everyone, so veterans should have access to a treatment plan customized for their individual needs. These curated plans often work better than standardized treatment options (ALAHC, 2013).

**PTSD as Loss of Control, Gain of a Stigma**

What does unite all veterans that suffer from PTSD is their experience of the loss of control and gain of a stigma. The physiological symptoms take over their bodies and minds; veterans will often perceive the sudden onset of symptoms as a sign of failure and an inability to control their environments. Many veterans find that although they showed excellent control in
combat, the physiological features that kept them alive during combat are poisonous to normal civilian life. They no longer see the world as a safe place, but rather one that is dangerous and predatory. These PTSD victims also discover that the belief systems and personal identities that defined them before combat have been shattered (Finley, 2011). In this way, the loss of control stems from no longer feeling anchored to the world or to themselves (Hoge, 2010; Paulson & Krippner, 2007). This loss of control also fuels a stigma; people who cannot control themselves are perceived by society, and subsequently by themselves, as weak and potentially dangerous (Hoge, 2010).

Dickstein, Vogt, Handa, and Litz (2010) indicated that veterans are hesitant to seek help for PTSD due to society’s stigma against people with mental illnesses. Members of the armed forces have been trained to project an image of self-reliance, which further stigmatizes those who may be suffering from PTSD (Mittal et al., 2013). This stigma discourages many veterans from seeking help for their symptoms and thus leaves them in a state of disempowerment and inertia (Dickstein et al., 2010). In order for veterans to receive the help they need, they must confront any existing stigma and consent to treatment for the disorder. Veterans are able to combat public and personal forms of stigma by actively challenging the negative stereotypes of PTSD sufferers since the act of challenging these stereotypes is a positive action towards healing (Mittal et al., 2013).

Access to a supportive environment also decreases the stigma associated with a diagnosis of PTSD and receiving treatment. A study conducted by Kelley, Britt, Adler, and Bliese (2014) discovered that veterans who have access to a positive environment, or, more specifically, positive perceived organizational support (POS), are more likely to seek necessary treatment. Conversely, an unsupportive environment functions as a powerful barrier to treatment for many.
veterans. Creating a supportive environment in which veterans can receive help enables them to seek treatment and take responsibility for their recovery (Hoge, 2010). The experiences of select veterans from the Second Battalion, Seventh Marine Regiment (2/7), deployed to Afghanistan in 2008, illustrate the negative impact an unsupportive environment can have on veterans suffering from PTSD. In *The New York Times*, David Philipps reported that from the approximately “1,200 Marines who deployed with the 2/7 in 2008, at least 13 have killed themselves” and that “the resulting suicide rate for the group is nearly four times the rate of young male veterans as a whole and 14 times that for all Americans” (2015, para. 9). Veterans from this battalion claimed that their VA sponsored therapists provided them with unwanted medications and, in the experience of one veteran, characterized his PTSD symptoms as being “‘like a bad breakup’” (Philipps, 2015, Failed Therapy section, para. 2). Experiences such as these left many former Marines without access to effective treatments and a lack of control over their treatment options.

Doctors present their patients with barriers to treatment when they do not give them access to treatments that work for them as individuals (ALAHC, 2013). When doctors take exclusive command of a veteran’s treatment options, veterans end up surrendering their authority and agency. PTSD robs soldiers of control over their lives, and successfully resolving PTSD symptoms requires sufferers to retake control and responsibility for themselves (Hoge, 2010). When veterans obtain control over their treatment options, this return of agency and responsibility helps empower them towards recovery. Veteran Robbie Myers became one such success story when he went from homelessness to winning a Food Network cooking competition and gaining his own television show. Myers believes that his decision to get help for his PTSD enabled him to change his life for the better (Byrnes, 2015). Far from abdicating responsibility for their mental health, most veterans acknowledge that their recovery is ultimately in their hands.
Cheyenne Forsythe, a veteran who blogs about his PTSD recovery, stated that “We can’t do it on our own. It’s going to take our families, group therapy, medication and one-on-one psychotherapy for many of us to get back some normalcy in our lives” (2011, para. 9). Forsythe echoed a sentiment shared by many veterans: they are willing to do the work but need the resources, and ability to access these resources, in order to heal.

Marquet’s “leader-leader” model has the potential to empower veterans since it balances authority throughout a power system rather than from above (Marquet, 2012). In the leader-follower dynamic, those with power are the leaders, and those lower on the hierarchy are followers. Marquet explained that, in the contrast to the “leader-leader” dynamic, the “leader-follower” power structure disempowers subordinates. In addition to stripping followers of responsibility for their actions, the leader-follower dynamic removes the agency and control of followers. Marquet redefined the power structure on his submarine, the Santa Fe, by giving former “followers” both control and responsibility over their jurisdictions. More often than not, the ship’s sailors rose to the occasion and acted with authority since they knew they were accountable for their actions. The submarine had formerly suffered the stigma of being the worst in the Navy, but Marquet’s actions transformed it into one of the best. Marquet claimed that, “What happens in a top-down culture when the leader is wrong? Everyone goes over the cliff” (2012, p. 81). When veterans are disempowered by not having access to necessary treatments, the veteran suffers, the VA suffers, and the Armed Forces suffer as a result of the “leader-follower” dynamic.

**Conventional and Unconventional Treatment Options**

Veterans who have power over their treatments will have access to a larger array of treatment options, both conventional and unconventional. Official treatment modalities are
endorsed by the VA due to their statistically-proven efficacy (Hoge, 2010). According to the
VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress (Department of
Veterans Affairs & Department of Defense, 2010), conventional treatments for PTSD such as talk
therapy (individual and group), medication, and cognitive processing therapy (CPT) and
prolonged exposure therapy (PET), are effective in treating PTSD. Other studies confirm the
efficacy of these frontline treatment methods (Mott et al., 2013). During exposure therapy,
subjects are gradually exposed to PTSD triggers in order to inoculate against problematic
triggers. Psychologists have concluded that PET reduces the negative effects and symptoms of
PTSD for many veterans (Zalta et al., 2014; Taylor et al., 2003).

Despite their statistical success, conventional, evidence-based therapies do not help all
those who suffer from PTSD. For example, while traditional counseling helps many veterans,
about 30% report that this treatment modality does not benefit them (Kresge, 2015).
Additionally, variations of traditional therapies also offer hope to sufferers. There is evidence to
suggest some veterans will experience a greater reduction of symptoms through untraditional
modes of therapy. A study lead by Mott et al. (2013) and an analysis conducted by DiMauro
(2014) indicated that some veterans experience a greater reduction of symptoms through group
exposure therapy than in traditional individual PET. Other veterans have benefitted from Virtual
Reality Exposure Therapy (VRET) or through the use of “mobile health (mHealth)” applications
via devices such as smartphones (Hoge, 2010; Erbes et al., 2014). Virtual and mobile means of
therapy still need further study for their effectiveness to be proven as “evidence based” treatment
options (Hoge, 2010). The diverse translation of traditional exposure therapy by medical
practitioners testifies to its customizability. In this case, one size certainly does not fit all.
Allowing a veteran to receive his or her desired medium of therapy helps reduce the stigma of receiving help (Hoge, 2010).

Due to their statistically-proven efficacy, the VA also endorses the use of certain selective-serotonin-reuptake inhibitors (SSRIs) for the treatment of PTSD. The drugs sertraline (Zoloft) and paroxetine (Paxil) are proven to help reduce the PTSD symptoms of many veterans. For example, a 2000 randomized study confirmed that subjects who received sertraline experienced a greater reduction in PTSD symptoms than those who received placebo (Brady, et al.). Marshall, Beebe, Oldham, and Zaninelli (2001) also concluded that paroxetine significantly reduced the PTSD symptoms of subjects. Perhaps because of these studies, only sertraline and paroxetine are officially sanctioned by the Food and Drug Administration (FDA) for the treatment of PTSD (Jeffreys, 2014). Matt Jeffreys, the medical doctor who wrote the “Clinician’s Guide to Medication for PTSD” on the Department of Veterans Affairs’ PTSD resource webpage, cited the studies conducted by Brady et al. (2000) and Marshall et al. (2001), which confirmed the statistical efficacy of paroxetine. This adherence to evidence-based treatments demonstrates that government agencies endorse empirically-backed treatment modalities as primary treatments for PTSD.

While many veterans derive tangible benefits from the use of medication, these same pharmaceuticals cause problems for others. Those who do not respond well to preferred SSRIs may discontinue the use of sertraline and paroxetine due to side effects such as increased anxiety and sexual dysfunction (Hoge, 2010). Overmedication is another concern for veterans with PTSD. Marty Callaghan (2014) reported on the American Legion’s April 30, 2014 written testimony on veterans’ care before Congress, stating that, according to the Legion, the VA often recommends medication over other therapies that may be more beneficial. The American Legion
noted in its testimony before Congress that many veterans are overprescribed medication because the VA does not have the personnel and financial resources to offer non-pharmaceutical alternatives to veterans who seek them (ALAHC, 2013). Special Ops veteran Jayson Floyd reported that when he sought help from a psychiatrist for his PTSD, she medicated him but also refused to talk about his symptoms (Waugh, 2015). Medication is often easier to administer and less costly than other treatments (Hoge, 2010). The American Legion believed that medication is thus being used in lieu of Complementary Alternative Medicine (CAM) that could help many veterans (ALAHC, 2013).

Although less common, innovative treatment options may not have the empirical backing of more traditional modes of therapy such as cognitive behavioral therapy, counseling, or medication, many veterans are still helped by CAMs. The American Legion recommended that Congress fund the VA to specifically invest more time and money into researching alternative methods for treating PTSD. Innovative treatments, including equine therapy, virtual reality therapy, music therapy, yoga, and nature-inspired therapies, have improved the PTSD symptoms of veterans treated in private hospitals (ALAHC, 2013). Yusra Kauppila, a former Marine who also suffers from PTSD, found that yoga was the primary treatment that helped her control her symptoms (Kwan, 2015). Kauppila further claimed that yoga allowed her to challenge the stigma of getting help. She noted that Marines are “supposed to be tough. My mentality was not to slow down, to not pay attention to my body” (Kwan, 2015, para. 2). Kauppila also asserted that “as a yogi, pain is your body’s way of telling you something needs to be addressed” (Kwan, 2015, para. 4). While testimonies such as Kaupilla’s remain anecdotal, yoga’s efficacy for the treatment of PTSD does, although not to the extent of PET and CPT, have empirical backing. A 2014 study conducted by van der Kolk et al. indicated that yoga was an effective adjunctive treatment that
reduced the PTSD symptoms in 52% of the study’s participants. This study demonstrated that CAMs are beginning to gain traction as viable, evidence-based therapies that are empirically-proven as capable of helping veterans recover from PTSD.

On the Department of Veterans Affairs’s official website for PTSD, doctors Strauss, Lang, and Schnurr (2015) do admit that CAMs have an adjunctive value to veterans who suffer from PTSD. Still, since CAMs are not offered at all VA Medical Centers, veterans who are unable to access them end up without viable treatment options. According to The War Within: The Findings of the TBI and PTSD Ad Hoc Committee, all VA Medical Centers should standardize their offerings of both traditional and CAM treatments (ALAHC, 2013). Hoge (2013) argued that doctors should, more often than not, focus on therapies that had statistical support behind them, he also acknowledged that veterans who are not best served by these treatments have access to alternative therapies. Hoge (2010) asserted that veterans are not numbers and that each veteran has very individual needs. On the other hand, Hoge (2013) later reasserted his position that CAMs have adjunctive value and should not replace evidence-based therapies as the primary treatments for PTSD. What Hoge does not consider is that many veterans are not helped by officially-sanctioned PTSD therapies. The statistical success of a particular treatment means little to the veterans it does not help, so these veterans should, by virtue of a “leader-leader” power structure, be able to determine what treatments work best for them as individuals and also be granted access to their chosen treatments. Since there is no single comprehensive treatment that will work for all soldiers, the Department of Veteran Affairs must ensure that veterans have access to both common and uncommon treatment modalities (ALAHC, 2013).
Conclusion

Just as there is no single comprehensive treatment for PTSD, there is no all-encompassing reason why the system breaks down for veterans who seek help. While the VA provides excellent care for some veterans, others become stuck or lost in the bureaucratic system that was originally designed to help them. Doctors prescribe effective treatments for lucky veterans while others become guinea pigs for ineffective treatments. The VA and its medical personnel do not intend to fail veterans, but veterans are often victims of the institution’s shortcomings. Veterans who do not have some control over their treatment and recovery will have a harder time recovering from PTSD since recovery means regaining control of themselves and their lives. Veterans can only be empowered to heal themselves if they are provided with access to treatments that will help them at the individual level. Instead of the “leader-follower” dynamic that permeates the U.S. Armed Forces, a “leader-leader” dynamic should define the relationship between veterans, medical professionals, and support administrations.
References


dsm5_criteria_ptsd.asp


http://dx.doi.org/10.1080/08995600903417399


http://dx.doi.org/10.1037/mil0000038


