“There is no better way to put it,” said SSgt. Mark M. “I was acting totally squirrelly. I was definitely not sleeping right. I was always shifting moods with my wife and kids, and I know I was drinking too much. I also developed a really weird feeling that I wanted to avoid going to my unit drills, even though I had always really enjoyed my National Guard unit and my buddies.”

Mark is a high school teacher who is well respected in his hometown. He reports that his family and friends typically ignored his strange behavior, and he assumes they were thinking that it was just a phase of readjustment, which would pass. It did not—in fact, it got worse as time went on.

Mark did get the help he needed with his problems, but it was not until he happened to attend a returning veterans social event where he met some other recently returned soldiers who were part of a veterans support group in town. That particular group of soldiers quickly picked up on Mark’s situation because they knew the signs.

When veterans return from combat today, one of two primary scenarios will occur. One: They will remain on active duty with their military unit, in which case many “homecoming and reintegration” resources and programs will be provided by their military organizations. Two: They will return to the civilian world as newly discharged servicemembers or as Reserve or National Guard members released from their active duty tours. The second scenario is one in which hometown individuals and organizations, including active and retired military members, can perform a major service for returning servicemembers—much like the support group did for Mark.

People at home can be a source of vital assistance to veterans if they know what to look for and how to respond.

**Emotional Trauma and Combat Stress**

Adapting information from American Psychiatric Association diagnostic criteria provides the following description of the conditions leading to emotional trauma from combat: A person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and that person’s response involved intense fear, helplessness or horror. When these two criteria occur, post-traumatic stress disorder (PTSD) or other stress disorders may result. Obviously, combat veterans are potential victims of stress disorders.

Since awareness of combat stress
problems has recently been expanded, leading to improved intervention and treatment, the percentage of veterans who will experience full-blown PTSD is lower now than in the past. The key to maximum effectiveness in treating the disorder is early recognition and treatment.

The major signs and symptoms of PTSD and related disorders are:

- A generally depressed demeanor, perhaps with occasional unexplained anxiety.
- Nightmares that may or may not be related to actual past experiences.
- Other sleep disturbances—any sleep abnormality that interferes with normal, restful sleep.
- Decreased interest in pleasant activities, including loss of appetite but also a lack of interest in hobbies, family events, social life and the like.
- Flashbacks—intense “reliving the event” experiences which sometimes involve several or all of the senses.
- Intrusive memories—while not as intense as flashbacks, these unwanted remembering episodes intrude on the normal state of mind.
- Physiological reactions—increased heart rate or breathing, the shakes, sweating and so on that accompany an intrusive memory or occur unexpectedly.
- Cue-related reactions—for example, a victim may drop to the ground when hearing a loud gunshot-type sound.
- Sexual dysfunction—may be an unusual decrease or, more rarely, an increase in sexual desire or activity.
- Amnesia— inability to remember traumatic events.
- Hyperstartle—a “jump/jerk” reaction to an unexpected stimulus.
- Hypervigilance—a persistent “looking over the shoulder” phenomenon.
- Atypical irritability or anger outbursts—especially a pattern that is abnormal given the individual’s pre-trauma behavior pattern.
- Excessive alcohol or other drug consumption—including overuse of anti-anxiety or antidepressant prescriptions, or use of illegal drugs.

According to the diagnostic guidelines, there is potential PTSD if several of the symptoms occur one month or more after the individual is removed from the trauma-causing environment and if these symptoms significantly interfere with normal family, work or social functioning. It is typical for some of these symptoms to be present in people who are returning from combat theaters. The primary concern is whether or not the symptoms diminish significantly within a month or so after coming home and that the symptoms do not seriously affect normal everyday life.

Some Medical Facts

PTSD and other stress disorders may have physical components. Medical research has shown that several important neurotransmitter functions can be changed, including those of serotonin (which is related to calmness) and beta-endorphins (which affect pain thresholds).

Diagnostic radiology studies of the brain show that some PTSD victims have visibly different brain function from unafflicted people in response to certain kinds of stimuli. These physical brain changes appear to be permanent or at least extremely long lasting. This does not mean that all PTSD and stress-disorder victims have brain or neurochemical changes, but some do. Knowing the psychological signs can help get people with these physical disorders the medical diagnosis and treatment they need faster.

Recent studies have brought attention to a type of injury called mild traumatic brain injury (MTBI). This kind of injury has been recognized as sometimes having signs and symptoms that are virtually identical to those of PTSD. There are various causes for MTBI. Any blow to the head, even when protected by a helmet, can cause an MTBI. Sometimes the effect may come from one incident, and other times it may be the result of two or more. It is unfortunate, but getting one’s head banged around is not uncommon in combat operations. With MTBIs, the important point is that the behaviors and experiences of the servicemember may be virtually the same as a combat stress disorder. It is not important to know whether the signs and symptoms are from combat stress or an MTBI; what is important is to recognize when they are present. Either cause can have the same result and needs expert diagnosis and treatment.

Whether it is social and/or psychological support, or those combined with medical treatment, veterans with PTSD, other stress disorders or MTBIs
need care as soon as possible. It is well known to professionals that the earlier the treatment begins, the quicker and more successful the recovery will be.

Diagnosis May Be Uncertain

Even those who are skilled and experienced professionals may find that stress-disorder diagnosis is difficult. Note that it is not necessary to have PTSD or an MTBI to have some very problematic stress-disorder issues. The study of stress disorders is a rapidly growing field. Increasingly, clinicians are learning that classic PTSD is not the only significant problem.

It is now recognized that stress disorders may be caused by factors other than intense direct personal combat. The stress may be of lower intensity over a longer period of time. Issues can be carried over from previous experiences, such as in the case of war on terrorism troops who also served in the first Gulf War. What was not critical stress to a person in one instance may become so in a later situation, especially if there are diminished physical, emotional and spiritual states. The combat episode that causes the problem may be the first, middle, last or a combination. Determining the details of the causes is the task of the therapist, but everyone concerned with combat veterans ought to know the basic symptoms and what to do.

Effective, Appropriate Responses

Many homeland support groups do a wonderful job of supporting servicemembers while they are deployed. Army Spc. Chris D. described the support he got from his hometown religious congregation: “They continually sent e-mails that encouraged me and let me know that they were praying for me. Their St. Anne’s Guild, along with other members of the parish, sent letters and care packages for me and my fellow soldiers. It is incredibly uplifting to know so many people are thinking of me and my fellow soldiers and what we had to do out there. To know that they loved us and supported us was very essential to our morale.”

Support of this nature is provided by a variety of religious, civic and service organizations. Chris D.’s story has been recounted with slight variations by hundreds, if not thousands, of deployed servicemembers. But responses to returning veterans are not always so supportive. This is not because the people on the home front are uncaring. More likely, they do not really know what to do. This was the case with Mark M., recounted earlier. People around Mark apparently assumed that a seemingly warm and considerate “he’ll get over it if we show some tolerance for his odd behavior,” would be enough. Unfortunately, it will not be if the veteran is experiencing real stress-disorder problems.

If someone notices the signs and symptoms of stress disorders previously described, what can and should be done? There are a number of good possibilities. If one is a combat veteran from previous wars, it may be helpful to approach the recently returned servicemember who is exhibiting stress-disorder symptoms and say, “I remember how some of my experiences
bothered me when I got back to the normal world. Are you having any feelings like that?” If this opens the door, follow up with offers to help get in touch with combat-stress resources.

Those who have not experienced combat need to be aware of this: It has been documented that veterans may not want to communicate about their traumatic experiences with people who have not had that type of exposure. Veterans can talk often to other combat veterans, but it may be uncomfortable or difficult for them to have similar conversations with non-veterans.

This does not mean that a person without combat time should avoid trying to help. It is appropriate for nonveterans to tell a veteran, “I don’t know exactly what you have experienced, but I feel it seems to be bothering you. If that’s the case, can I do anything to help?”

Another useful approach can be: “I’ve never experienced combat or that kind of stress, but I know there are some people who have and can help veterans. Would you like for me to help you get in touch with them?”

Direct, honest and simple comments and questions like these are often enough to make the initial breakthrough with the veteran. When a veteran sees that someone cares and understands what he or she is going through, a sense of reassurance and comfort can develop, and the door is opened to getting the needed professional care.

**Combat Stress and Trauma Care**

First, a cautionary note: When looking for a support group for recently returned servicemembers, it is always worth the effort to determine if there is a local veterans organization with members who are recent combat veterans. This latter part is important because, although the experiences of veterans of previous wars might eventually connect for new veterans, the older veterans are usually not seen initially by the new ones as having had the same kind of feelings. Referring a recent veteran to a group that is made up mostly of older veterans from the Vietnam War and earlier conflicts will probably not be as helpful as to a group composed primarily of those from the most recent conflicts.

This is not a problem with older veterans; it is a perception of some of the young soldiers. Since perceptions are reality for those who hold them, this issue is worth considering when looking for support groups and resources.

MilitaryOneSource.com is a website that has, among other resources, a 24/7 veterans hotline: 800-342-9647. The counselors are skilled at on-the-phone assistance. More important, they can set up confidential, no-cost appointments at nearby counseling centers to help with urgent issues. They can also assist family members who wish to call.

There is an outstanding online resource to help combat veterans and others understand potential stress-disorder problems. Created by the Military Operational Medicine Research Program, www.battlemind.org features separate videos for soldiers, leaders and spouses. These videos provide excellent insight, information and suggestions.

Locations of Department of Veterans Affairs (VA) facilities can be found at www.va.gov/directory or in the telephone directory under U.S. government listings. Recent initiatives have made the VA increasingly capable in the combat stress and trauma treatment field, and the facilities often have readily accessible support groups and counselors. Encouraging a veteran to get in touch with them, or even assisting in making a call or visit, is an excellent option if the veteran seems to be having serious problems.

It is usually not advisable to send a veteran to a counselor or facility that is not experienced with combat stress/trauma. If there is no veterans-specialty care available, this may be the only option, but a general care counselor or facility will usually not be able to meet the particular problems of veterans most effectively. That capability typically comes from combat-stress specialty counselors. This is
not a criticism of the excellent general mental-health counselors who may be practicing in a given area. It is, however, a recommendation based on reports of combat veterans.

An important final suggestion is that civic and service organizations and religious congregations sponsor a recent combat veterans support group. Local news media will likely be very supportive in publicizing the meetings. If a veterans’ counselor is available to lead, the group should be relatively easy to start. If no counselor with that background is available, any good support-group leader can help get the group going and then back out of the process when a few key members learn the basic group facilitation skills. This type of support group is a needed resource in most communities.

Servicemembers who stay on active duty after their combat tours have these groups available as a regular part of their homecoming and reintegration process. But recently discharged veterans and reserve component personnel returning to their civilian communities often do not, unless some local organization takes the initiative to create a program.

Learning the basics of combat-stress disorders, making some efforts to encourage affected veterans and creating some local support groups can make a tremendous difference in the lives of recent combat veterans by providing the bridge between the hometown citizens’ awareness and concern and the excellent veterans special care that is available.

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