



Center for the Study of Traumatic Stress

Understanding the Effects of Trauma and Traumatic Events to Help Prevent, Mitigate and Foster Recovery for Individuals, Organizations and Communities
A Program of Uniformed Services University, Our Nation's Federal Medical School, Bethesda, Maryland • www.usuhs.mil/csts/

FROM INJURY TO HOME:

Integrating Networks of Medical and Psychosocial Support on the Road from Battlefield Injury to Recovery

When battlefield injury occurs far from home, the road to recovery may be long and difficult to navigate. Even with the dedicated support of medical professionals, loved ones, military leadership, and brothers and sisters-in-arms this pathway from injury to home requires caring over time and over miles. Differences in the type of injury, in the nature of support available along the way, and the types of resources and responsibilities waiting at home may dictate different stops along the way for different service members.

Movement from care at the point of battlefield

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injury (physical, psychological, or combined) through levels of care abroad and within the US and ultimately homeward is a complex process involving the interplay of personal endurance, military and medical leadership, technology

and communications and networks of civilian and military caregivers, supporters, and communities. The modern evacuation and movement of injured provides new opportunities for care, necessary tracking and communications and needs for protection from additional health burdens, both physical and administrative.

Programs and policies that must integrate and synthesize the efforts of command, community, and family resources have to consider the following areas at each stop along the route from hazardous duty to adaptive home life, and include:

- 1) Over 20,000 service members have sustained injury in the war in Iraq. Approximately half of these have been serious enough that the service member has been unable to continue to function in theatre and has required a medical evacuation back to the continental United States. The injuries include but are by no means limited to traumatic amputations, loss of sight, and traumatic brain injury. The emotionally injured may also be evacuated. Importantly, even severe emotional injuries may not be readily apparent on the battlefield and occur in greater numbers as home approaches and the challenges of return meet the worries of lost health and function.
- 2) The “invisibility” of psychological injury presents a complex medical situation in which denial, stigma, fear of re exposure to painful memories and lack of knowledge of treatment options and efficacy impede help-seeking and strain an already stressed system of care resources. Administrative procedures can become part of secondary injury. While on the other hand, when health systems create opportunities to miss care, the combination of
- 3) Most serious combat injuries powerfully impact the children and families of service members. Longitudinal data suggest that problems do not immediately resolve and commonly worsen during the course of the first year after hospitalization. Difficulty in readjusting to life back home may alter family relationships and support contributing to a vicious cycle of psychosocial challenges for both the injured service member and the family. The family is the care collaborator in all health interventions and planning.
- 4) Returning combat veterans, even those not psychologically injured, experience a variety of behavioral and emotional responses secondary to their war experience. Distress symptoms are common and may include insomnia, nightmares or other forms of sleep disorder, hyper vigilance, jitteriness or overexcitement; and avoidance or social withdrawal. Reintegration with family and life is both a goal and can be a challenge.
- 5) Systems of care must address not only disorders, but the many emotional and behavioral manifestations of distress. They must incorporate healthcare provided by military, VA, and civilian treatment facilities; facilitate family participation in health care and treatment plan-

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ning; and engage traditional community resources (e.g., churches and schools) as well as employee and local, state, and federal programs implemented specifically to provide assistance to returning veterans.

- 6) Secondary injury can result from the induced helplessness, overwhelming stress and indignities resulting from administrative delays, errors and omissions, which may unnecessarily complicate recovery.
- 7) Variability in the time and emotional availability and responsiveness of family members requires resources and flexibility in order to identify and establish care advocates for each injured service member.
- 8) People returning from combat deployment can sometimes initiate or increase the frequency of risk behaviors that compromise their health and the health and safety of those around them. Excessive alcohol use may develop as a misguided attempt to reduce stress. Irritability or anger (common symptoms on return home) may turn into violence, at times directed to one's family, in the context of excessive alcohol use or the decreased emotional control that can accompany Traumatic Brain Injury.
- 9) Medical advances and current practice have altered the amount of time an individual may remain in a specific care environment. Rarely in the modern world of war is the injured now in theatre or even overseas for long periods of time. Yet healing and administrative processes still take time and hold patients in new settings where family may or may not be present and resources have to be constantly adjusted to meet needs. Resources have to

be sufficient and flexibly assigned to meet each level of care in order to sustain the recovery process and be responsive to the cultural context of the injured and geographical considerations (i.e. those residing in rural or remote locations).

- 10) Current processes of medical evacuation generally provide for superb initial stabilization and management of physical and psychosocial injuries to service members within the military medical system. However they do not well address the longer-term challenges associated with care across boundaries of community, family, VA and civilian medical services. The care of injured from battlefield to home must be re-engineered to incorporate the new health care available, the technology and transport and the varied effects of injury on family members, the subsequent impact on the nature and availability of family resources to the injured service member, and the range in available resources during evacuation and at home station over time.
- 11) Navigating the complexities of ongoing medical care and disability evaluation is in and of itself a health challenge and a health burden. It can be an impediment to the intrinsically human process of adaptation to serious physical or emotional injury.. Navigating this complex road requires acknowledging the injury's impact on one's identity, one's future, one's family and one's livelihood. Such knowledge changes how we view our self and our family. And can change how our family and friends view us and our future. This adaptation, recovery and return requires time and community to sustain the process.

For further information see:

- 1) "From Battlefield to Home Front: War Psychiatry", summary of a conference held to address the changing health care needs of modern war and combat.
<http://www.centerforthestudyoftraumaticstress.org/downloads/WarPsychiatryExecSumUrsano-2005.pdf>
- 2) Resources of the Center for the Study of Traumatic Stress of the Uniformed Services University. www.usuhs.mil/csts or www.centerforthestudyoftraumaticstress.org

