

## Post-Deployment Syndrome in U.S. Active Duty Military and Veterans. The Difficulty in Recognizing the “Illness of War”

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In 2014, the United States Senate designated the month of June as post-traumatic stress disorder (PTSD) Awareness Month. The National Center for PTSD ([www.ptsd.va.gov](http://www.ptsd.va.gov)) invites everyone to collaborate. The actions of this initiative are summarized in: LEARN about PTSD, CONNECT to resources that can help; SHARE with others to spread the word.

2.77 million US military personnel have served in Afghanistan and Iraq in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) since the beginning of these conflicts in 2001. These major international conflicts were the first since the Vietnam War that required a great number of troops on the ground. About 50 nations have contributed troops to both conflict areas, but the majority of those deployed at any one time have been from the US: as of March, there were about 13,500 NATO troops in Afghanistan, including about 9,000 Americans. Considering the years before, between September 2001 and 2015, 1.33 million individuals serving with the Army deployed abroad, along with 563,000 from the Navy, 518,000 from the Air Force and 367,000 Marines. Quite a few service members have multiple deployments under their belts with around 225,000 soldiers from the Army deploying at least three times or more, particularly those in the special operations community. To mention one of these extreme situations, we want to remember the case of Delta Force Master Sgt. Joshua L. Wheeler who became the first US soldier to die in combat against ISIS and the first American to lose his life in Iraq for four years. After he died during a successful raid on an ISIS prison facility during Operation Inherent Resolve, it emerged that he was a veteran of 14 combat deployments to Iraq and Afghanistan.

The repeated deployment of troops does not increase exponentially the risk of being killed; it also involves an increasing exposure to iatrogenic factors [1]. Indeed, “deployment to a war zone is an experience that may profoundly impact a veteran’s health and personal life, carrying the risk of long-term physical, psychological, and social impairments” [2]. Obviously, this risk is significantly different between members serving in the red high-exposure areas (e.g. intense firefight or battle with a great deal of injury and killing) or in the green low-exposure areas (e.g. killed-in-action comrades’ bodies preparation for return stateside) [1,3]. Each of these exposures is potentially devastating and may actually cause similar symptoms, but clearly, they are different. The major signature conditions of the wars for US member service and veterans are traumatic brain injury resulting from current combat operations (mTBI/concussion) and PTSD [1]. Macera and colleagues [4] pointed out that blast-related injuries might disclose the development/worsening of symptoms during the months following deployment. Importantly, those who have been affected by PTSD and TBI in Operation Iraqi Freedom formed a unique group, with the presence of TBI intensifying development of PTSD symptomatology [4].

However, the majority of health, neuropsychiatric and neuropsychological complaints for the military personnel are relatively underestimated. In particular, it is supposed that approximately one in five men and women returning from service in Iraq and Afghanistan experience lasting physical and psychological injuries consistent with Post-Deployment Syndrome (PDS). Some conservative estimates confirm that at least 400,000 U.S. troops have been impacted with PDS [3]. This syndrome incorporates all the signs and symptoms experienced because of the injury, deprivation, trauma, and stress of combat [3].

Clinical and research experts do not fully agree on what PDS is, when symptoms reach a threshold to be labeled as PDS or when they're something else, and when the same symptoms are significant enough to warrant different types of treatments [3]. Despite this difficulty in recognizing the syndrome, many service members and veterans report common symptoms that appear to be “PDS drivers”, such as difficulty falling or staying asleep irritability, headaches, and poor concentration [3]. More than a dozen of chronic unexplained symptoms might complete the PDS constellation: anxiety, appetite abnormalities, changes in taste/smell, depression, difficulty hearing, difficulty in making decision, dizziness, fatigue/loss of energy, loss of balance; memory complaints, nausea, nightmares, numbness in parts of the body, poor coordination/clumsiness, poor frustration tolerance, poor concentration sensitivity to noise/lights, slowed thinking, vision problems/blurring [3,5]. Moreover, chronic widespread pain is a component of this syndrome, producing significant disability and considerable health care costs [5]. To use the words of Cifu and Blake [4], the presence of PDS is reasonably suspected when soldiers are dealing with “more than just a single symptom or two, more than just the results of a single injury, more than just a reaction to stress, and more than just some minor difficulty readjusting to home after a tour of duty” [3]. Importantly, this symptom constellation must “be fairly consistent in nature and intensity, be significant enough to limit some aspect of your day-to-day functioning, be there for at least 3 months after all physical injuries have healed, and/or be there for at least 3 months after a return to home”.

Considering the above, it is important that all health care personnel be familiar with the unique health care needs of active duty and veterans, which include not only injuries associated with blast exposures (including mTBI/concussion), but also several mental health conditions, such as combat stress disorders, PTSD and PDS. Other important health concerns must be considered chronic unexplained medical symptoms, as well as musculoskeletal pain and hypertension, sequelae of environmental exposures, behavioral abnormalities and depression, substance abuse, sleep disturbances, and impairments in family, occupational and social functioning [2]. All these conditions can affect more or less seriously on soldiers' health and day-to-day functioning. Importantly, these dysfunctions persist long after the initial insult or injury is over, and anyway over the period of adaptation to being back-home has been completed or the times typically needed to heal.

Although PDS has traditionally been attributed to combat exposure, it is also true that in any war troops that were in the rear have developed the same symptom constellation. Indeed, “providers should recognize the late development of symptoms, consider the possibility of comorbidity, and be prepared to treat multiple symptoms rather than a specific diagnostic category” [4].

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