Working with Iraq War Returnees and Their Families:

Key Issues and Clinical Dilemmas

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Framework for a discussion

- Who are our clients?
- Why do they seek treatment?
- What key issues are raised by cohort demographics?
- In the session: Foci of treatment
  - How does combat stress affect the family?
  - Spiritual trauma
- Creating a new context of care

Who are our clients?

- Active/Inactive Reservists; members of the National Guard—may experience multiple deployments
- Veterans separated from service
- Parents/partners

Why do they seek treatment?

- Somatic concerns (fear of heart attack, worry about GI problems): enter system via GMC
- Sleep problems, anxiety: might also seek entry through GMC
- Road rage/anger dyscontrol -> employment, legal issues
- Disruption in relationships with family/friends
- Academic concerns (assignments are “missions”; boredom)
- Want jobs as first responders

Cohort demographics and related clinical issues

- Age
- Gender

Age

- Age variation
  - Reserves/Guard: 18-60 years old
  - Likely did not expect to be deployed
  - Often married, financial responsibilities, children (or grandchildren)
  - May be veterans of other conflicts
- Many in Navy/Marines are 21 or 22 years old
  - Comfortable with technology; game-boys
  - May have been eager for deployment
  - Often working or in school

Key clinical issues related to cohort Age

- How do we make the treatment environment acceptable? (concern about the stigma of mental health interventions)
- How do we make the treatment environment available to returnees who are working, or in school?
- How do we address issues of meaning and spiritual trauma? A new lexicon?

Gender

- 16% of the active US Armed Forces are women.
- Women in wide range of combat & leadership roles/ responsibilities (gunners)
  - "Suck it up...get over it...take it like a man"
- Stress of war seems to be associated with increases in rates of sexual harassment and assault

Key clinical issues related to cohort Gender

- Military sexual trauma (MST)/childhood trauma can exacerbate stress reactions to combat exposure
  - Military sexual trauma (harassment/ assault) can be used to enforce traditional roles
  - Beliefs about culpability in combat can be potentiated by self-blame related to unresolved childhood trauma

Key clinical issues related to cohort Gender

- Identity issues
  - "I'm not supposed to cry"
  - "I'm not a woman; I'm a soldier"
  - "My [7 year-old] daughter supports my decision to go back to Iraq… we're alike. [T: how did you know?] I gave her a flag and she waved it at me when I left."
  - "My son was too clingy when I got home."
  - "The only fabric I'm comfortable with is Kevlar…it has no give, it doesn't break or bend" [when metaphor of therapy as woven narrative was used]

Key clinical issues related to cohort Gender

- "I'm not fit to be seen by you...I'm not civilized" [hiding her head in her hands when discussing anger directed at Iraqi prisoners she was guarding during a transport]...[and later, when discussing her love of art and cooking:] "I need to keep that split off and separate...that's the beauty part."

  - from a 37 year-old female intel officer following her posting to Abu Ghraib

In the session

Focus of treatment	Related issues
Hypervigilance	Paranoia, traffic violations, securing home perimeter, trust grounded in combat terms: "what's your motivation?"
Hyperarousal	Anxiety, anger, sleep difficulties, substance use, "adrenalin addiction" -> boredom, risk taking
Problems framed as somatic concerns	"Quick fix"; BZD dependence

In the session

Focus of treatment	Related issues
Redeployment ambivalence	Worry about danger in warzone vs. felt lack of meaningful role/not "fitting in" at home; wish to "be there" for fellow soldiers. Concern that redeployment may affect career, academic, life plans; promotion/layoff concerns for Guard/Reserve.
Ethnocultural issues	Prolongation of childhood community violence: the neighborhood as warzone Epithets: "ragheads, hadjis"

How combat stress affects families

- Combat stress can interfere with veteran's ability to trust and be emotionally close to others – family members may feel cut off.
- Triangulation may result if veteran bonds to a parent who is also a veteran (e.g., mothers feel "left out"; reinforces veteran's belief that s/he can only be understood by another vet).
- Veteran may be irritable, and have difficulties communicating.

How combat stress affects families, con't.

- Veteran may experience loss of interest in family social activities.
- Veteran may lose interest in sex and feel distant from his or her partner.
- Traumatized war veterans often feel that something terrible can happen "out of the blue", and can become preoccupied with trying to keep themselves and family members safe.

How combat stress affects families, con't.

- Veterans who have committed/witnessed acts of violence (especially against women and children) may feel that they are now unsafe to be around loved ones – and so disengage.

- Family members may be reluctant to talk about the trauma and related problems – to spare the veteran further pain, for fear of veteran's reaction, for fear of their own reactions.

Spiritual trauma

- An aspect of human experience not adequately defined by the DSM-IV
- Traumatic events tend to raise spiritual questions:
  - Shattered just-world assumptions (Janoff-Bulman): **The world is safe, predictable, controllable; The self is worthy; Life has meaning**
- Attachment ambivalence:
  - "If I get close to someone, something will happen to them" or, "I'll hurt them"
  - "I feel abandoned by God" or, "I can't go to church anymore"

Clues in the Narrative: Schemas about Power

- “I liked it...having that power...to decide who lived and who died...I wore the uniform, and I got respect...I don’t feel respected anymore.”

- “I feel like a loser now that I’m home.”

Clues in the Narrative: Schemas about Beauty

- "It started when I was watching this commentator...she was standing on a roof, and there were SCUDS flying, and there were minarets in the background...[T: and?]...it's the Tigris Euphrates...you know, the seat of civilization" (Vietnam veteran whose re-experiencing sxs worsened as he watched the early TV coverage of the war)
- "It's the Tigris f-ing Euphrates, man...[T: and so?]...it was the Tower of Babel...now it's a debris field" (42-year-old soldier in the active Guard)

Clues in the Narrative: Schemas about Beauty

- What looks to be perfectionism — efforts to complete “the mission”, or reestablish power and control — can mask the quest for the esthetic: the search for transformation

  - “I had the soap dish arranged just so — it was blue, to match the towels, and she [his 10-year-old daughter] used the bar soap instead of the liquid.” (recounted after veteran’s wife requested family session, subsequent to his aggressive acting out at home; when asked whether he had experienced anything in Iraq as beautiful, he burst into tears)

The countertransference dilemma for the clinician

- Fear of knowing the details of war, concern about managing affect/dissociation -> failure to pursue material, forgetting details
- Desire for mastery over fear/curiosity about the details of war -> probe for too much detail

Creating a new context of care

- Acceptability: "post-deployment adjustment", not "PTSD"; normalize/ anticipate sxs; peer outreach; exercise/ recreational therapy; informal interventions
- Accessibility: evening hours/telemedicine
- Family intervention: Parent's and Partner's Groups
- Teaching resilience ("psychological armor") to active duty/redeployable clients:

  The Risk and Resiliency Model

The Risk and Resiliency Model

- Devolved from an effort to understand factors that affect odds of acquiring combat stress.
- "The experience of war is transformative" – can be rewarding, challenging, resulting in interpersonal maturation and promote growth.
  - Self-efficacy
  - Identity; sense of purposefulness, belonging, pride
- "What can you learn from your experience?"

Risk and Resiliency Factors: A Complex Interaction

- Pre-military
  - Social class, family instability and conflict, early trauma, childhood antisocial behavior, hardiness (commitment and determination)
- Combat stressors
  - Combat exposure and perceived life threat/ trauma severity, peritraumatic dissociation, injuries, witnessing/ participating in atrocities, everyday discomforts, unit culture
- Post-War
  - Perceived social support, distressing events, family and community re-integration

NCPTSD 29 Palms Study (Leskin, 2004)

- PTSD highly correlated with low score on Change In Outlook (CIO) Scale
  - **I value my relationships much more now**
  - **I know my priorities about what is important in life**
  - **I live every day to the fullest now / I have an appreciation for the value of my own life**
  - **I feel more experienced about life / I know I can handle difficulties / I have a feeling of self-reliance**

- Strongest predictors of high CIO score:
  - Post-deployment support
  - Training and deployment preparation

Research Into Practice

- **Encourage disclosure; staying connected.**
- **Focus on meaning making.**

  - Coping skills training (sleep, relaxation, conflict resolution, mindfulness).
  - Address psychosocial needs.
  - Educate soldier/family about homecoming expectations.
  - Encourage soldier's active involvement in health care.
  - Emphasize previous commitments, goals, plans.
  - Praise soldier for what s/he has accomplished.
  - Encourage attention to spiritual needs.
  - Treat the family.

Resources

- www.NCPTSD.org: The Iraq War Clinician's Guide
- www.ISTSS.org
- NCPTSD Clinical Training Program