

# **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


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

# In the session

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

# 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 sx’s 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 sx’s; 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](http://www.NCPTSD.org): The Iraq War Clinician's Guide
- [www.ISTSS.org](http://www.ISTSS.org)
- NCPTSD Clinical Training Program

