Treating Post-Traumatic Stress Disorder (PTSD) Related to Military Combat

This question-and-answer article was stimulated by the documented mental health needs of active duty military, National Guard, Reservists and veterans who have served in Operation Iraqi Freedom and in Operation Enduring Freedom in Afghanistan.

Terence M. Keane, PhD, is director of the Behavioral Science Division of the National Center for PTSD at VA Boston Healthcare System. He is also professor and vice chairman of the Division of Psychiatry at Boston University School of Medicine and professor of psychology.

The author of more than 200 publications and editor of nine volumes on Post-Traumatic Stress Disorder (PTSD), Dr. Keane also has developed many of the most widely used measures of psychological trauma and PTSD. He is recognized internationally as a leading authority on PTSD and trauma.

Randy Phelps, PhD, is deputy executive director of the American Psychological Association (APA) Practice Directorate and has worked for many years on veterans issues.

Dr. Phelps: Where do individuals who have returned from combat get treated for their mental health needs?

Dr. Keane: The Department of Veterans Affairs (VA) operates an integrated health care system that provides services to men and women who were injured during their military service or who developed a disease/disorder during the time of their service. Additional eligibility is conferred on those whose annual income is below a certain level and who do not have alternative sources of health care available to them. Elderly veterans over the age of 65 can also receive care at VA. Further, an act of Congress created time-limited eligibility for National Guard members and Reservists to use VA services. Approximately one-third of eligible veterans who served during the current conflicts in Iraq and Afghanistan have been to a VA setting for some type of care. Of course, combat-related PTSD is the most common psychological problem. But veterans also present with depression, substance abuse, chronic pain, traumatic brain injury (TBI) and other anxiety disorders.

The vast majority of veterans and their family members receive their mental health care from the private sector. For this reason, it’s important for mental health practitioners of all types to assess for veteran status. Making this determination may provide important information for case formulation and treatment planning.

Dr. Phelps: What is important for psychologists to know about the demographics of returning service members?

Dr. Keane: Several key demographic features of the current military force are important to appreciate. First, it is a decidedly diverse, multicultural military. More than 40 percent of active duty military personnel is a racial or ethnic minority. This figure represents greater diversity than in the U.S. population at large.
Second, women constitute more than 10 percent of the military serving in Afghanistan and Iraq, and they perform a wide range of professional roles and combat roles. This situation is different than Vietnam, for example, when women were disproportionately represented in nursing and administrative positions and served in the war zone in far lower percentages of the total military force.

Third, there is a bifurcated distribution of age among service members. Some members serving in their first enlistment might be in their late teens or early twenties. Others are Reservists and National Guard members who might be in their later thirties or forties. Accordingly, their backgrounds and issues are very different and reflect their age, vocational and family structures.

**Dr. Phelps:** How do family members – spouses, children, parents and others – factor into treatment for returning service members?

**Dr. Keane:** Veterans themselves are the ones deemed eligible for VA care. The VA’s statutory authority to treat family members is limited.

Family members are treated to the extent to which they are directly involved in the veteran’s care. For example, if a veteran develops depression or PTSD as a consequence of his or her service, the veteran’s spouse could be actively involved in a marital treatment program for these conditions. If a veteran is injured by an improvised explosive device (IED) and his/her cognitive processes are compromised, the parents could be involved in a psychoeducational rehabilitative program in conjunction with the veteran. This treatment would be fully provided by VA to the veteran and his or her family members.

**Dr. Phelps:** How generalizable are skills in treating trauma to treating people exposed to combat? How likely is...
Dr. Keane: I’d like to think that the specific skills and conceptual models for understanding and treating one type of trauma are directly generalizable to another form of trauma exposure.

Yet, specific contextual factors are important to consider if one is to succeed in navigating the transition from working with one group of trauma-exposed people to another group. In the instance of combat trauma, it is critical to understand general military contextual variables and the specific details associated with the war itself, and to have an appreciation of the stressors and pressures under which the individual served. Even understanding the political climate in Afghanistan or Iraq during the time of service may communicate to your patient important things about your competence. Learning about the contextual factors associated with a particular type of trauma exposure would, in my view, be far easier and quicker to master than the acquisition of new therapy skills.

The principles for treating trauma survivors are far better understood today than 30 years ago when we first started to treat combatants. Importantly, the models and techniques that guide psychological assessment and psychological treatment of PTSD now possess reliability and validity data that transcend the various types of trauma to which people are exposed. These same principles appear to be effective across racial, ethnic and cultural boundaries.

Dr. Phelps: What is important for practitioners to know about the combat-related experience that today’s returning soldiers may bring to treatment that’s different from other trauma-related life experiences?

Dr. Keane: Fundamentally, trauma is about exposure to life-and-death situations. Trauma may also be secondary to exposure to events that challenge one’s personal integrity or may inculcate shame or humiliation. For combatants, their experience in a war zone may transcend all of these experiences and exposure to these experiences often happens multiple times over the period of service.

Combat is not exposure to a uniform, single traumatic event. Rather, it often involves multiple types of life-and-death experiences associated with strong and wide-ranging emotional reactions in the context of a malevolent living environment that is estranged from the usual forms of family and social support. As a result, it’s vital to conduct a comprehensive assessment of exposures both in the war zone and prior to service in the war zone.

My experience is that veterans can be extraordinarily open in describing the devastation of war but may be reluctant to express details of events in which they might have had an active role. Patience is needed to understand the precise role of the individual in certain war events, their immediate reactions to those events and the long-term impact of this participation. Combatants are often actively and passively involved in acts of violence; understanding the boundary conditions of war is pivotal in making progress in the psychological treatment of war veterans regardless of their rank at the time of service.
**Dr. Phelps:** What specific treatments show the greatest promise for successful treatment of combat-related PTSD?

**Dr. Keane:** The general principles that guide treatment of PTSD are derived from several different models of care. First, the development of a strong therapeutic alliance is pivotal for all future work. It may determine the extent to which particular patients might even share with you the details of their military experiences. Conflict about one’s participation in combat is a function of what one does in the war zone and what happens to that person in the war zone. The complex emotions that emerge can be fear, anxiety, dread, horror, shame, guilt and disgust – the strongest and most aversive of human emotions.

Treatment of these emotional responses initially involves a quieting of the strong emotions often employing relaxation or meditational strategies, accompanied by psychoeducational efforts to inform the patient of the psychological, physiological and interpersonal consequences of trauma exposure. Reframing the experiences using cognitive restructuring models that focus upon realistic appraisals of the situation and the circumstances found in a war zone by combatants also is an important component of psychological care. Finally, emotional processing of the details associated with difficult combat events is also demonstrably effective in helping patients to overcome their reactions. Emotional processing can take many forms, including prolonged exposure therapy, systematic desensitization, eye movement desensitization and reprocessing (EMDR) and other approaches that focus directly upon the emotional reactions precipitated by the traumatic events per se.

**Dr. Phelps:** Psychologists are trained to pay attention to countertransference. But are there potential blind spots for certain practitioners, such as those unfamiliar with military service or opposed to war, that they should be mindful of in working with returning service members?

**Dr. Keane:** The therapeutic alliance can be a challenge in any setting and with any type of patient, but there are some key features that will determine whether veteran patients will return for continuing care. Listening attentively to the description of service, while asking informed questions about location, duties and training, can communicate to the veteran an understanding of their experience in important ways.

Most people who join the military do so for the honor and defense of their country. Their belief system is such that they respect those who join the military and they consider the work of the military among the most worthwhile things possible. Challenging this belief or even demonstrating a political position on the value and merits of a particular war may inadvertently damage the therapeutic alliance in ways that aren’t remediable.

For many war veterans, even those in their eighties today, the work they did for their country in the military was among the most rewarding life experiences they’ve had. Supporting this belief is important to moving to the next stage of treatment.

**Dr. Phelps:** What is the Department of Veterans Affairs doing to help psychologists – both VA psychologists and non-VA psychologists – become better informed?

**Dr. Keane:** The National Center for PTSD has an award-winning Web site, [www.ncptsd.va.gov](http://www.ncptsd.va.gov), with a special emphasis on combat-related PTSD. The PILOTS (Published International Literature on Traumatic Stress) literature search engine, one of the most widely used facets of the Web site, contains both published and unpublished works on the topic of trauma, including chapters in books from across the world. PILOTS can be accessed directly from [www.ncptsd.va.gov](http://www.ncptsd.va.gov).

At the moment there are two initiatives within VA to bring effective treatments to all corners of the VA mental health system. Several treatments appear to help veterans and others to overcome symptoms of PTSD: Exposure Therapy, Cognitive Therapy, Anxiety Management (for example, Stress Inoculation, Stress Management) Treatments, EMDR, combinations of the above treatments and psychopharmacological treatment using serotonin-acting medications. These treatments are identified and described in the most recent edition (in press; Guilford Press) of the International Society for Traumatic Stress Studies (ISTSS) *Best Practice Guidelines for PTSD*.

Further, several colleagues and I are involved in a project that will disseminate evidence-based approaches to the assessment of PTSD nationwide. We have developed a Best Practice Guideline for PTSD assessment. Following a recommendation from the Institute of Medicine, the VA will disseminate these best practices to bring uniformity to the process of evaluating veterans seeking compensation for psychological war injuries.

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With more than 1.6 million troops deployed to serve in the Middle East since September 11, 2001, psychologists around the country are spearheading volunteer efforts to help service members and their families deal with psychological issues related to deployment.

For example, 1,000 licensed mental health professionals who volunteer nationally with Give an Hour provide free and confidential treatment for anxiety, depression, substance abuse, post-traumatic stress disorder, sexual health and intimacy concerns, and loss and grieving to veterans.

Give an Hour also offers its services to parents, siblings and unmarried partners who are not entitled to receive mental health benefits through the military. “Our goal is to provide easy access to skilled professionals for all of the people affected by the war,” says Barbara Romberg, PhD, the organization’s founder. “The healthier the support system for the returning troops, the lower the risk of severe or prolonged dysfunction within these military families.”

Other volunteer efforts provide similar confidential services. Jaime Darwin, Psy.D., and Kenneth Reich, Ed.D., both members of APA Div. 39 (Psychoanalysis), co-direct Strategic Outreach to Families of All Reservists, known as SOFAR. Division 39 partners with this project that offers psychotherapy, psychoeducation and support services to extended families of National Guard and Reserves deployed in Afghanistan and Iraq from deployment through return and reintegration. “When a soldier serves, the whole family serves,” Darwin says.

Based in Massachusetts, SOFAR is starting chapters in New York and Michigan. “Our ultimate goals are to build resilience and to prevent intergenerational transmission of trauma,” says Darwin.

State, provincial and territorial psychological associations are also aiding volunteer efforts. For example, the “Support Our Family in Arms” task force, or SOFA, by the Colorado Psychological Association, has coordinated its efforts with both Give an Hour and SOFAR. According to Chairman Edward Cable, PsyD, SOFA provides a wide range of pro-bono psychological services to National Guard members and Reservists and their families.

Dr. Cable finds that volunteering time and talent confers many benefits. “Not only is it a way to repay our veterans for the sacrifices that they have made physically and mentally,” he says. “It is an opportunity to educate the public about the services that psychologists provide and to make them aware that we are compassionate professionals.”

For more information:
Give an Hour: www.giveanhour.org
SOFAR: www.sofarusa.org
SOFA: Contact Dr. Cable at drednc@comcast.net