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Article 70

How Have the Wars in Iraq and Afghanistan Impacted the Troops, Their Families, and the Mental Health Community?

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> *The extremely dangerous and unpredictable conditions faced continuously by an unseen enemy can be overwhelmingly difficult. When 'leaving the wire' or the somewhat protected environment of the Forward Operating Bases soldiers are exposed to relentless possibilities of attacks from civilians, soda cans, dead animals, or abandoned vehicles, all of which can be easily converted into deadly Improvised Explosive Devices. They maim, torture, and kill their victims with grisly burn and blast injuries. There is no escape from the danger they pose. We hold our breath every time we leave the safety of our compound (the Green Zone).* (Platoni, 2005)

War is one of the most psychologically, physically, cognitively, and emotionally demanding and stressful situations that people can find themselves in, even with the best of military training and preparation (Rizzo & Kim, 2005).

As the Global War on Terrorism, now referred to Overseas Contingency Operations, continues past its eleventh year mark, over 1.7 million United States military members have served in Iraq, Afghanistan, and 20 major bases around the world, with major concentrations of troops in 11 countries (Kessler, 2012). Some military members have endured a severe financial, physical, psychological, emotional, and spiritual toll (Figley, 2005).

Two specific populations of these war fighters, the Army and Air National Guard, are America's "Citizen Soldiers" and "Citizen Airmen." In past wars and conflicts, they were deployed for a short period of time or were involved in state missions to include search and rescue efforts, snow or ice storms, flooding, fires, or other national emergencies, such as Hurricanes Katrina and Irene. The Reserve and National Guard members are typically have a part-time commitment to the military and their transition

from civilian-military-civilian makes it more challenging to gain access to services and having a supportive environment (Werber et al., 2008). National Guard and Reserve members are disproportionally at risk for mental health problems, with reservists more likely to need mental healthcare services following deployment (Schell & Marshall, 2008; Werber at al., 2008). Those who deploy may experience additional stressors on themselves, their families, their jobs, and their communities. National Guard Soldiers and Airmen sometimes received orders at the last possible minute, placing a greater strain on part-time military members and employers, and potentially lost their civilian jobs due to numerous deployments. Despite laws that support military members through the Employer Support of the Guard and Reserve Program, during this faltering economy, these veterans are more at risk for unemployment than those not serving in the military (ESGR Program Seeks, 2004.).

The longer that National Guardsmen have been away from their families, jobs, and communities, the greater the changes and challenges they face (Hosek, 2011). Communities evolved: one's peer group may have changed due to veteran vs. non-veteran or political perspective. The veteran's new physical or psychological health may have created a small or drastic change, with coworkers feeling uncomfortable interacting with the veteran. With the current faltering economy, jobs may have disappeared or companies closed down. The veterans may have returned to jobs where their peers have been promoted and moved ahead while the veterans return to lower level/different jobs. Families may have changed; some spouses and children may be estranged from the combat veterans. Spouses or teens may have developed the habits of drinking, drugs, or sexual promiscuity. Older family members may have developed serious chronic health problems or died while the military members were deployed (Military One Source, 2010).

The most frequently reported sources of stress were being away from family and lengthy deployments (Kang, Natelson, Mahan, Lee, & Murphy, 2003). Increased deployment length was also related to increased mental health problems and marital problems. Communication patterns between the veterans and their families also may have changed (Hinojosa, Hinojosa, & Hognas, 2012). Those findings are particularly important due to an increase of deployment length from 12 to 15 months in Iraq and Afghanistan in April 2007 (Tyson & White, 2007).

Anecdotal observations and surveys suggest that significant numbers of returning soldiers from *Operation Iraqi Freedom* (OIF) and *Operation Enduring Freedom* (OEF) in Afghanistan face the possibility of Combat Operational Stress Reactions (COSR), Post Traumatic Stress Disorder (PTSD), or other psychological symptoms that cause them to have mild to extreme adjustment challenges after their deployments (Cozza et al., 2004; Hoge, 2005; Hoge, Auchterlonie, & Milliken, 2006; Litz & Orsillor, 2004).

Knowledge of post traumatic stress has been available for decades, and it has also been referred to as 'shell shock,' 'war neurosis,' and 'soldier's heart' since the Civil War. The U.S. military continues to search for effective methods of assisting the troops to return to healthier methods of coping in order to return to combat operations (Coleman, 2006). The military services will need the help of community mental health providers to support the veterans and their families.

A survey of 2,530 troops prior to and after deployment to Iraq reported that one in eight Iraq combat veterans (between 15 and 17%) was reported to suffer from major

depression, generalized anxiety, or PTSD (Hoge et. al, 2004). One of the most foreboding findings in the report was the observation that for Iraq and Afghanistan veterans "whose responses were positive for a mental disorder, only 23 to 40 percent actually sought mental health care" (Hoge et al., 2004).

The soldiers worried that they would be stigmatized by their leadership and peers for seeking help and that asking for support would negatively impact their military careers. (Tanielian et al., 2008). Some veterans have asked their spouses to make counseling appointments in the spouse's name, and the veteran attends as a "support system" to keep the stigma of mental health appointments hidden from their fellow troops and commanders.

These soldiers have deployed not only once, but some more than five times in various combat or stressful areas where combat equals danger, fear, boredom, high adrenaline activity, and the possibility of one's own death or the loss of a battle buddy. Research indicates that deployed soldiers with pre-existing symptoms of anxiety and depression may have a higher risk of PTSD (Barak, Bodner, Klayman, Ring, & Elizur, 2000; Vogt, Pless, King, & King, 2005). Other notable symptoms that soldiers diagnosed with PTSD exhibit may include substance abuse and sexual problems (Iowa Persian Gulf War Study Group, 1997). These soldiers may experience the loss of intimacy with their spouses or partners (Cantrell & Dean, 2005).

Their symptoms may predate their service in Iraq or Afghanistan, but have been exacerbated by new experiences in combat. For others, their symptoms of mental health distress were a direct result of combat and operational pressures. Some soldiers developed substance abuse problems upon their return home; other soldiers at Walter Reed National Military Medical Center and the Veterans Affairs Hospital in Gainesville, Florida, suffer from severe wounds and loss of limbs that lead to long-term rehabilitation and permanent disability. Others experience a combination of these problems – and most spouses and families are ill-equipped to understand that their loved one will never be the same (U.S. Department of Veterans Affairs, n.d.). Many of their symptoms go unreported and Soldiers may not trust that the VA or mental health system will understand or support them.

How can the mental health, social work, and marital, couple, and family therapy disciplines rise to the monumental task of assisting these Americans and their partners? Some wounds don't end with the war. The Pentagon has scrambled to close gaps in care by creating more than 200 programs, but that has invited waste, duplication, and a lack of oversight, according to a recent Rand Corporation report (Hosek, 2011). However, that range of options sometimes throws Reserve members into a "sea of web sites with no idea of where to go to find appropriate care" (Cantrell et al., 2008).

"It may be impossible… to fully counteract the shock of going home from a 24-hours state of generalized fear – apprehension – paranoia, sustained for a year through wartime, to evenings at home on the La-Z-Boy, and being asked to fulfill the requirements of love and tenderness to sustain a family" (Corbett, 2004). The stress of frequent deployments, being away from family and support systems in the civilian community, and the continuing hyper-alertness of a potential battle zone with a constant risk of being wounded or killed is harmful to the health of our Soldiers and their families. Research has also shown that if spouses and families aren't supportive of their military

loved one, the military member will either seriously consider leaving the service or experience additional stressors from the pressure of their family (Figley & Nash, 2007).

An additional stressor is serving the veteran 6 months to 5 years later when additional symptoms become unmanageable for the veteran. This may include sexual trauma issues, homelessness, substance abuse, and inability to do tasks of everyday living that may be compounded by breathing problems, sleep apnea, and depression (Litz, 2004).

Some recent studies have investigated the effects of frequent deployments on National Guard soldiers and their spouses or partners. The Kansas State University Institute for the Health and Security of Military Families, found at http://militaryfamilies.k-state.edu/ (part of the University's Marriage and Family Therapy Program), under the direction of Briana S. Nelson Goff, has examined the consequences of deployment and separation of military couples. Nelson Goff's studies examine resiliency factors that enable couples to grow closer in spite of the separation and trauma of the combat zone. The Couple Adaptation to Traumatic Stress (CATS) Model by Dr. Goff provides a systemic description of how individual and couple systems were affected when trauma occurred. This empirically-informed model includes a description of the mechanisms by which trauma impacts the primary trauma survivor, secondary partner, and couple relationship. Quite simply, it suggests that the model is circular, and symptoms of secondary trauma in the partner may intensify symptoms of primary trauma in the spouse. The CATS Model proposes that adaptation to traumatic stress in the couple is dependent on the systemic interaction of the individual level of functioning of both partners, predisposing factors and resources, and couple functioning. This suggests that individual symptoms in primary trauma survivors affect the stress levels and traumatic symptoms in their partners. The results of her study indicated the following conclusions: some veterans return from the war zone and discover that their reintegration into families, jobs, and communities a relatively easy task. On the other hand, many soldiers, especially those with physical and mental health disabilities, will experience huge barriers and difficulties (Nelson-Goff, 2007).

In couples where both spouses are members of the military, one may come home while the other rotates to the war zone, creating uncertainty and lack of communication about daily routines. These families experience extremely high levels of continuous stress. The return from deployment is never simply a "Welcome home, we missed you, and now we can pick up where our lives were before you went off to war." War has far too great an effect and the gap left in the family during deployment is much too deep (Military One Source, 2006).

Additionally, the war in Afghanistan, with 1,813 U.S. casualties, was not included in the count of over 4,485 casualties from the Iraq War. The severely injured are not included on the casualty list, and will eventually return to their hometowns or where the families can become their caregivers (iCasualties.org, n.d.).

This war will leave many physical and emotional casualties of military members, their families, and the community. One study found that being an "agent" of killing the enemy (rather than being the "target") is the most pervasive trauma of war (Fontana, Rosenheck, & Spencer, 1999).

To comprehend the whole system of comprehensive healing involves the veterans, families, military branches, civilians, and communities. Each strategic piece of the healing circle allows veterans to begin their individual healing processes.

During basic training, trainees were assured that they would receive appropriate sustenance in the form of monetary compensation, education, health care, and other benefits for their military service. However, many veterans of the current wars now believe that these were empty promises and that the trust has been voided by the government and our society (http://IAVA.org website). This concept includes the political and media's portrayal of success in Iraq and Afghanistan (Goodman, 2004). The perceived betrayal gives rise to despair and/or rage. Some veterans are disheartened that their sacrifice and that of their fellow and sister military personnel was for naught (Goodman, 2004).

Interest in the marriage and couple relationship of the National Guard members has increased dramatically in recent years. Since the beginning of the Global War on Terrorism, National Guard units have been deployed numerous times, with some members serving up to four or five tours. This has caused National Guard members, who have traditionally served in shorter deployments, to experience stress within their marital relationships and an increase in divorce upon their return.

Researchers have determined that the number of suicides from combat veterans and young white male non-combat veterans have increased by 30% in the ranks of the National Guard and Reserves, who have not been able to, nor have chosen to access VA or community services. The Army's active component had a slight decline in suicides in 2010, while those in the Reserve component rose by more than a third, to 122, with virtually unprecedented numbers through most of 2011, according to the Army Suicide Prevention Program. The actual number is probably higher, however, because the Army's count does not include activated reservists who killed themselves.

Mental health providers working in conjunction within the Family Readiness Centers need to recognize the importance of "buy-in" from the service member's spouse/partner. There is a need for additional research to determine how to assist military members and their partners in creating resilient relationships and families. This can only be accomplished with a coalition of community services, counselors, and public awareness of the challenges of being a deployed National Guard member and spouse/partner.

As mental health and counseling providers, it is our responsibility to understand the military cultures (since each service has a culture of its own), and to respect the thoughts and ideas of the specific challenges of the military family. With 50,000+ veterans recently home from Iraq, there will be additional stressors on these service members and their families. Some National Guard veterans are being deployed once again to the Horn of Africa and other locations. It is the responsibility of our communities to assist those who have served. President Obama is urging employers to support/hire veterans and many regions of the United States are planning job and career fairs. Educational benefits are also increasing for returning veterans through Post 9-11 GI Bill program.

The Department of Veterans Affairs cannot respond to all of our returning veterans and their families. The children of these veterans require the help of knowledgeable school counselors with an appreciation of the sacrifices of families during

the past 11 years America has been at war in OIF, OEF, and 20 major locations around the world. National and community support of organizations including Give an Hour, (www.giveanhour.org), Tragedy Assistance Program for Survivors, (www.taps.org), Iraq and Afghanistan Veterans of America (www.iava.org), and the National Guard's Psychological Health Program, will continue to be essential for our veterans and their families.

More information is needed for families and mental health providers about traumatic brain injury and post traumatic stress. These are the hallmark injuries of this generation's combat service members. Assisting families to adapt to their physically and psychologically wounded returning Soldiers is vital to healthy communication between families and their veterans.

Veteran service organizations, to include Veterans of Foreign Wars, the American Legion, AMVETS, and Disabled American Veterans, need training on the behaviors and challenges of working with traumatic brain injuries and post traumatic stress behaviors. These interpersonal challenges of combat-injured veterans include unleashed anger outbursts, limited memory, hyper-vigilance, and the inability to concentrate or focus on tasks while under stress.

Now, more than ever, the counseling community must unite to serve those who have served. Yet all is not bleak or hopeless. Many veterans, with assistance and encouragement, have experienced post traumatic growth. They are becoming the stabilizing force in neighborhoods and cities around the country and bringing their leadership into the workplace. In many situations, healing is possible when our newest vets are told, "Welcome home, Sister! Job well done, Brother!"

And for those of us in the counseling profession, our duty is to affirm our veterans and welcome them home safely, no matter what our personal opinions and beliefs about war and politics might be. It is the least we can do - to add peace to their souls and help them identify and restore joy in their lives as they begin life in their "new normal."

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Military Resources

Give an Hour
Give an Hour is a non-profit organization providing free mental health services to U.S. military personnel and families affected by the conflict in Iraq and Afghanistan.
http://www.giveanhour.org/skins/gah/home.aspx

Iraq and Afghanistan Veterans of America
Offers veterans and their families legislative information, mental health treatment information, and a community of veterans (on-line) support system
http://iava.org)

Military One Source
Military One Source is a free service provided by the Department of Defense to service members and their families to help with a broad range of concerns including money management, spouse employment and education, parenting and child care, deployment, reunion, and couple and family counseling needs.
www.militaryonesource.com

Tragedy Assistance Program for Survivors
Tragedy Assistance Program for Survivors (TAPS) is the 24/7 tragedy assistance resource for anyone who has suffered the loss of a military loved one, regardless of the relationship to the deceased or the circumstance of the death. TAPS provides comfort and care through comprehensive services including peer based emotional support, casework assistance, crisis intervention, and grief and trauma resources.
www.taps.org

U.S. Department of Veterans Affairs
Offers veterans of all eras information about medical, psychological, educational, and house loan information.
www.vba.org

Veterans Crisis Line (1-800-273-8255)
Veterans Affairs mental health hotline in collaboration with IAVA for suicide prevention. In addition to the Veterans Crisis Line (1-800-273-8255 and Press 1) and online chat (www.VeteransCrisisLine.net), Veterans and Service members in crisis—and their friends and families—may text free of charge to 83-8255 to receive confidential, personal and immediate support. The text service is available, like the Veterans Crisis Line and online chat, 24 hours a day, seven days a week, 365 days a year and connects a user with specially trained VA professionals—many of whom are Veterans themselves.