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Iraq and Afghanistan Veterans: National Findings from VA Residential Treatment Programs

Joan M. Cook, Ph.D.^{1,2}, Stephanie Dinnen, B.A.¹, Casey O'Donnell, PsyD¹, Nancy Bernardy, Ph.D.^{2,3}, Robert Rosenheck, M.D.¹, and Rani Desai, Ph.D.^{1,2}

¹Yale School of Medicine

²National Center for PTSD

³Dartmouth Medical School

Abstract

A quality improvement effort was undertaken in Department of Veterans Affairs' (VA) residential treatment programs for Posttraumatic Stress Disorder (PTSD) across the United States. Qualitative interviews were conducted with over 250 directors, providers, and staff during site visits of 38 programs. The aims of this report are to describe clinical issues and distinctive challenges in working with veterans from Iraq and Afghanistan and approaches to addressing their needs. Providers indicated that the most commonly reported problems were: acute PTSD symptomatology; other complex mental health symptom presentations; broad readjustment problems; and difficulty with time demands of and readiness for intensive treatment. Additional concerns included working with active duty personnel and mixing different eras in therapy. Programmatic solutions address structure (e.g., blended versus era-specific therapy), content (e.g., physical activity), and adaptations (e.g., inclusion of family; shortened length of stay). Clinical implications for VA managers and policy makers as well as non-VA health care systems and individual health care providers are noted.

Keywords

posttraumatic stress disorder; veterans; health service needs; rehabilitation

For over 30 years, residential treatment has been a cornerstone of U.S. efforts to assist veterans with Posttraumatic Stress Disorder (PTSD) (Rosenheck, Fontana, & Errera, 1997). Its main purpose was to assist those whose need for treatment exceeds what can be provided in the outpatient setting. Until recently, these programs have predominately provided treatment to veterans who served in the Vietnam War (e.g., Johnson, Fontana, Lubin, Corn, & Rosenheck, 2004; Johnson, Rosenheck, & Fontana, 1997; Johnson et al., 1996). However, as a result of the recent wars in Iraq and Afghanistan, there is now a new generation of veterans who are presenting to residential treatment with war-related problems.

A substantial proportion of returning veterans have significant psychological symptoms, impairment, and disability, with almost one third suffering from PTSD, major depression, traumatic brain injury (TBI), or a combination (Schell & Marshall, 2008). These numbers are beginning to be reflected in utilization of health care services within the Department of Veterans Affairs (VA). For example, the number of Iraq and Afghanistan veterans receiving

VA services has increased from 18,896 in 2003 to 291,426 in 2009 (Desai, 2010). Since September 2001 to 2009, 3,496 Iraq and Afghanistan veterans have entered into intensive residential PTSD treatment, a number expected to increase (Desai, 2010).

Iraq and Afghanistan veterans have higher levels of acute PTSD symptoms and anger-related problems than veterans from other eras at time of admission to residential programs (Fontana & Rosenheck, 2008). In addition, they have shorter lengths of stay in and lower treatment satisfaction as well as lower levels of treatment engagement and adherence in treatment generally (Erbes, Curry & Leskela, 2009). These problems are likely in part derivatives of the distinct characteristics of these most recent military conflicts (e.g., extended tours, multiple deployments, increased likelihood of redeployment) (Hoge et al., 2004).

Delivering interventions to this new generation of veterans in PTSD residential treatment settings required providers to make revisions to existing program structure and content. The purposes of this paper are to: 1.) report on the challenging issues that PTSD residential treatment providers report encountering in their work with Iraq and Afghanistan veterans and 2.) note solutions from providers in addressing these challenges.

Methods

Participants and Procedures

As part of a mixed-method quality improvement effort, the Evaluation Division (i.e., Northeast Program and Evaluation Center; NEPEC) and Executive Divisions of the VA's National Center for PTSD collaborated in a site visit initiative involving VA PTSD residential programs in the U.S. that provide program monitoring data to NEPEC (N=38). Across the 38 VA residential sites, 267 staff were interviewed.

Prior to each site visit, the program director completed a comprehensive survey documenting program features including organizational structure (e.g., number of patients currently in program, staffing), program policies (e.g., admission, discharge), and services and treatments provided. A two-day site visit then occurred in which semi-structured interviews were conducted with directors, providers and staff. A structured interview guide was developed and refined during the first few site visits.¹ The interviewer followed a consistent set of domains (e.g., treatment, organizational functioning, continuity of care, and future of program) although wording and order shifted to maintain conversational flow. This allowed further exploration of relevant topics not specifically articulated in the interview structure. Interviews were conducted by a clinical psychologist (CO), and recorded on a voluntary basis with written permission. Additionally, when deemed appropriate and agreed to by all involved, participant observation in team meetings and treatment groups was conducted. Following site visits, the primary evaluator (CO) recorded field notes and debriefed with the investigative team (JC, NB).

One issue that became apparent during the site visits was the ongoing transition in patient populations and emerging needs programs were experiencing in response to growing numbers of veterans from Iraq and Afghanistan. The results presented here focus on directors, providers and staff perspectives on the unique challenges and solutions in working with this new generation of veterans. Since there appeared to be no substantive differences in opinion between these three types of VA employees, they are heretofore referred to collectively as providers.

¹A copy of the interview guide is available upon request from the first author.

Verbatim transcriptions of qualitative interviews were entered into Atlas.ti for coding and analysis (Muh, 2004). Narrative analysis proceeded systematically in three main steps: JC, SD and CO generated initial findings through independent review of de-identified transcripts; then condensed findings through comparison and team consensus; and created summary statements for each major finding. To facilitate interpretive analysis we developed top-level codes that described broad common themes within the narratives (e.g., most effective elements of treatment, organizational changes, benefits of residential programming, Iraq and Afghanistan veterans, etc.) then further sub-coded quotations linked to these top-level codes. Procedures used to ensure internal validity include semi-standardization of the interview, audio-taping and professional transcription, standardized data coding, and an iterative approach to thematic extraction.

Results

There were no significant differences between the 38 programs that currently report outcome data to NEPEC and took part in the site visits and the seven that do not report data to NEPEC in regards to number of operational beds ($\bar{X}$ =18.24, SD=11.11; $\bar{X}$ =14.71, SD=9.95, respectively), number of full-time employees ($\bar{X}$ =11.06, SD=6.81; $\bar{X}$ =9.53, SD=5.47) or type of program (e.g., PTSD Residential Rehabilitation Programs).

Of the 38 programs, 37 (97.4%) reported that the primary patient population served was veterans with PTSD; only one (2.6%) specifically focused on both PTSD and substance use disorders. Programs reported 5 to 98 days as the targeted length of stay ($\bar{X}$ =47.97, SD=21.15).

Of the 267 staff interviewed most were psychologists (n=109, 40.8%), followed by social workers (n=56, 21%), nursing staff (n=38, 14.2%), psychiatrists (n=18, 6.7%), and others (e.g., substance abuse counselors, admission coordinators, art therapists, chaplains; n=46; 17%). Staff reported a wide range of length of service in the programs from less than one year (16.3%) to 19 years or more (12.3%), with a mean of 6.6 (SD = 7.2).

Providers reported that in general younger veterans are different from the veterans from other conflicts, not only in obvious terms of age and recency of their deployment, but in regards to symptom presentation and treatment needs. Table 1 lists the providers' perceived differences between the veterans from Iraq and Afghanistan and the veterans from Vietnam and other theaters.

In addition it was noted that Iraq and Afghanistan veterans present a number of challenges to residential treatment including: PTSD symptoms are "raw" (fairly acute with relatively recent onset complicated by other mental health problems); broad-based readjustment issues (e.g., housing); difficulty with time demands of treatment; lack of readiness for residential treatment; some patients are still active duty personnel; and decision of whether or not mix to veteran eras in programming. As such, providers detailed a range of attempted solutions. Elaboration of each issue and emerging solutions are discussed in detail below as well as presented in Table 2.

"Raw" PTSD and Complex Mental Health Symptoms

According to providers, Iraq and Afghanistan veterans present with extreme anger, anxiety, lability, hypervigilance, and difficulties concentrating. While these symptoms are not exclusive to veterans from the current wars, the intensity of their symptoms appears particularly concentrated.

"Instead of dealing with ingrained behaviors and ways of thinking about things for 35, 40 years, we have people who are relatively fresh from their traumatic

experience. So the anger and the bitterness, the sadness, betrayal, the sense of loss and grief ... this really has a much different flavor. It's much more raw."

Providers also report struggling with how to maintain the pace of treatment considering the number of patients who have TBI-related problems.

"It's not that they are deliberately not progressing, but it slows down the program, slows down everybody else."

Although comorbid substance misuse is a commonly co-occurring problem with PTSD, providers note challenges relating to use in recent returnees. Providers report that young veterans are often in denial or minimization of the effects of their substance misuse and equate it with social drinking with friends.

"A great deal of binge drinking ... the toughest ones are the ones that drink socially...they're used to drinkin' with their buddies.... that's just what their buddies do on the weekends."

"You'll see a lot of people that say they don't want to treat their substance abuse problem, they want to treat their PTSD. I don't have a substance abuse problem, I have PTSD. They are adamant about that."

Similarly, the general increase in and access to prescription medications and chronic pain management problems in these veterans reportedly challenges both program safety and a veteran's ability to engage in and benefit from treatment.

"The prescription medication has been a huge problem. It didn't used to be, but with these veterans, it's just increasing."

"There is a significant portion of the returning vets who have pain problems or had them and then developed an addictive problem as well so you're managing either pain and the addiction or the addiction."

In order to assist in affect regulation of intense emotions, providers report that there is a great need for recreation and physical exercise for younger veterans. Some programs have incorporated physical activity into programming by utilizing kinesiotherapy, while others provide access to supervised gym equipment or offer outdoor recreation (i.e., walking trails, weight lifting,).

"The incorporation of physical exercise and movement in the program is really important. Is it the key piece? No, but it's an important piece."

"Other programming that we've built in to address the needs of more recent returnees is more physical activity, in particular we have an active bicycling program where they log in a phenomenal amount of miles and participate in various community-based, nationwide-based cycling events."

Providers report that treatment of veterans with PTSD and co-occurring TBI requires greater coordination and collaboration with other medical and social services as well as adjustment in patient goals.

"We have a polytrauma team ... We have strong neuropsychology here and we're very well connected with all these folks. We work closely together and still I think we need to find an integrated treatment of PTSD and TBI."

Similarly some programs are making adjustments in the length of stay for TBI patients.

"They actually get a little bit longer. That's an eight-week program instead of the seven-week. We wanted a little bit more time on assessment, so we do the full neuropsych as well as the full psychiatry and pain assessment, and speech. So since

we're assessing more, we need a little bit more time on the beginning and end to do all that."

Providers are also making adaptations in standard treatment parameters for those with comorbid TBI, such as increasing number of sessions to complete treatment-related tasks. Almost all programs acknowledged that TBI-related issues require the use of adaptive measures, such as the use of personal data devices, in treatment.

"We've had some guys that have had TBI's and PTSD who have used tape recorders in sessions."

"I audio-taped all the modules ... I simply just read them all onto the audio-tape ... because [the veteran] had difficulty reading."

Providers report that historically their programs enforced zero-tolerance policies for substance use. However many programs now engage in case-by-case decisions when determining disciplinary actions for substance use, particularly in Iraq and Afghanistan veterans.

Broad-Based Readjustment Problems

Providers explained that younger veterans in residential treatment appear to have a host of social, occupational and reintegration problems that can interfere with and complicate treatment. Providers report some of the veterans in their programs have lost their home, spouse/partner, and job. Thus, in addition to learning how to overcome their PTSD symptoms, these veterans face employment, housing, and relational difficulties.

"That's been a huge change, really dealing with what I call PTSD in adolescence... we're used to working with PTSD patients who burned their bridges a long time ago and now we're in the business of working with patients that are just learning how to burn 'em."

"We're seeing a lot more that maybe are not on the street, but they've been kicked out of the house...they may have a place to sleep, but it's not permanent housing."

Whether young veterans live with their parents or have new marriages and young children, residential programs are in the process of offering a range of services under the broad spectrum of family intervention. However, the providers unanimously reported that limited resources (e.g., time, additional staff) interfered with their ability conduct or maintain these interventions. Several have worked intermittently to establish partner groups or integrate family into treatment, yet time demands, geographic constraints and staffing limitations can inhibit the attendance of family or the ability of programs to offer such services.

"When a man, a husband and a father leaves the family to go to war this throws the responsibility of maintaining the family on the wife or the significant other and that can be a heavy burden... That creates a lot of conflict...for the younger veterans."

"How do you involve partners and wives in the care of the veteran in a way that is safe? Part of the barrier for us is that since many of our referrals are not local, we don't have access to those family members."

Some programs have been able to successfully address these barriers to integrate families into treatment. These include teleconferencing, hosting "wives groups," sponsoring family days with a focus on psychoeducation, and having a staff member trained and available to provide childcare and parenting skills classes.

"We could do phone sessions. We could even do video conferencing if we had the equipment. But then again it's a question of having trained staff who not only have knowledge of PTSD treatment but also of family systems work."

Difficulty with Time Demands of Intensive Residential Treatment

Providers explain that the average five to eight week length of stay is often difficult for young veterans to commit to as they are trying to find or maintain employment and sustain relationships with young families.

“It is really hard for our newly returning folks, that they have just been away for one or more successive deployments of sometimes months or a year and the family has been disrupted, the job has been disrupted, they are trying to catch up with their peers...and then you want to take them back out of it and put them in a somewhat sheltered, isolated environment.”

“These younger fellows ... they’ve got families, they are trying to hold down jobs ... In today’s world you can’t be gone for ten weeks.”

“With the younger vets, all they want is brief, focused treatment... they wanna get on with their lives.”

Thus several programs offer a shorter length of stay for younger veterans. For example, some programs with cohort (as opposed to rolling) admission intermittently treat cohorts in shorter timeframes for those unable to commit to longer programs. In fact, one program has allowed access for outpatient clients to attend specific residential program groups several afternoons per week.

Lack of Readiness for Residential Treatment

Providers report that there is often a general “resistance” to residential treatment in veterans from Iraq and Afghanistan. The hypothesized reasons for this include: veteran denial and minimization of difficulties; less experience or more discomfort with group therapy; still early in the course of recovery; difficulty disengaging from the “warrior mentality”; and fear of negative consequences on military careers from seeking treatment.

Providers note that while some returning veterans are motivated to learn skills to better manage their PTSD, others are overwhelmed by the prospect of being “institutionalized” for their problems. Providers suggested that many young veterans appear skeptical of residential treatment and feel restricted by its policies and procedures. Providers explain that these patients are often “not ready” for treatment, hence motivation and willingness become a primary component of treatment.

“The trend that I’ve seen is they’re more pre-contemplative, kind of resistant to change, resistant to treatment. And I think clearly it’s because they’re trained to be these warriors, these ultimate fighting machines. And they’re just months from returning from war and to accept treatment is a sign of weakness.”

“They know things aren’t working and they want things to change but they’re not quite faced with the wife walking out on them or they’ve lost that last job and now they can’t get another job.... So it’s a little tougher to get them to really sign on to practicing some of these emotional, risk-taking behavior changes.”

Providers note that some veterans struggle to establish an identity outside of their military lives. For some veterans, service-related disabilities may have derailed military careers. Thus providers explain that vocational rehabilitation is often necessary.

“For some of them, the Army was their first job; a few of them don’t have any formal education other than their grade school education. They’re still trying to figure out what they’re gonna do when they grow up.”

Additionally, providers report that veterans typically enter a residential program in a period of crisis related to the combination of in-flux housing situations, interpersonal conflict, substance misuse, and acute mental health symptoms.

“People are being admitted directly from acute psychiatry units ... They are coming in not believing they have a diagnosis of PTSD or any problems.”

“The new veteran cohort ... is not just coming here for intense treatment. They’re coming here for stabilization.”

“These younger guys are not only fresher with their trauma, but are less treatment savvy... we are trying to teach them to do treatment at the same time that they are trying to do treatment.”

Some providers report the use of specific interventions such as motivational interviewing to help younger veterans engage in treatment. Additionally, programs may use skill-focused shorter-term “tracks” to provide skills and increase readiness before engaging in a more traditional psychotherapy-focused programming.

Some Patients are Still Active Duty Personnel

A small number of programs have experienced an influx of patients who are currently active duty military. According to these programs, this can present conflicting treatment goals for patients. For example, providers explain that while only a small percentage of these soldiers are expected to redeploy, their military future is uncertain, and unlike their veteran peers are not readjusting to civilian life. In addition, ethical issues can arise as providers may feel conflicted between serving both their patient’s best interest and that of the armed forces. For example, the armed forces interests may include rehabilitation in order to return to duty and possibly to battle, while the providers’ primary interests are to decrease symptoms and increase functioning in the civilian world.

Additionally, providers suggest that some PTSD-related symptoms (i.e., hypervigilance) are functional while in combat, and training patients to overcome their arousal may not be perceived as useful by active duty soldiers.

“People who are still on active duty reserve, guard who may deploy again... if you reduce their situational awareness or their hyper-alertness... What happens is they go back to a combat environment and they’re at a total loss.”

“We want to make sure that we don’t open them up so much that they can’t go back and get redeployed ... and be even more vulnerable ... We really try to judge that and gauge our interventions accordingly.”

The primary approach to treatment of active duty personnel is attention to appropriate assessment to assist the military and the veteran to make a decision regarding ongoing service. Providers report that only a limited portion of veterans are recommended for ongoing military service for increased symptom severity is expected if the service member is re-exposed to combat. For that limited number, treatment focus does not include reframing of thinking for civilian context. Additionally, patients who are expected to redeploy are taught to discriminate between adaptive and conditional responses (e.g., situational awareness) versus maladaptive responses (e.g., hypervigilance).

Mixing Eras

Providers express a range of concerns regarding mixing recent returnees and other veterans (e.g., Vietnam veterans) in residential treatment programming. For example, a few programs report the generational and developmental stage differences along with symptom

presentation and significant disparities in historical social climate during war eras can create tension and disconnect.

“The young guys who are coming in come in with a real attitude towards these old guys... Like you have your experience, but my experience is different. And it’s not necessarily relevant and that’s often how it starts with a lot of tension.”

“I sat in a group where these guys were like, “I don’t understand why we’re being mixed. We work much better on our own.”

“The older veterans are not as enthusiastic about it. I’ve actually heard, “We’re not welcome anymore. They’re pushing us out.”

Conversely, mentorship is one of the benefits reported for integrating veterans of different eras. According to these programs, older veterans encourage younger veterans to address their PTSD symptoms early in life and often model the impact of coping with chronic symptoms. In return, older veterans are reportedly rewarded by the experience of mentorship and the chance to interact constructively with younger veterans. Additionally, providers explain that older veterans are often offered respect and gratitude for “paving the way” in treatment.

“We kind of assumed, and correctly, that the Vietnam veterans would be good mentors, father figures, fill that dynamic... One thing we didn’t anticipate as much ... is the Vietnam veterans will come up to you and say ... I look at that kid, my roommate, that 25-year-old punk, and you know what? I’ve really started to like that SOB. And you know why? He’s just like I was ... and they really are coming to a realization that that’s exactly how I was. And that’s powerful.”

“If you ask the younger veterans who have been through this program, they feel that being here with Vietnam veterans has been invaluable because they really learn things that the other guys have gone through and what kind of things not to do and what kind of things to pay attention to and it has been... I mean you see this kind of mentorship or relationships and that have been, I think, very, very helpful to them.”

In the few locations where groups are structured to be era-specific, there is generally era integration in didactically-instructed classes (e.g., PTSD psychoeducation). More often, programs fully integrate eras. For some programs this was a strategic planning choice as they reportedly find it beneficial. For others full integration was based out of necessity (e.g., limited staff to cover separate programming).

“When I first started the program we didn’t do any mixed groups and the conventional wisdom was that mixing the two eras didn’t work well because they wouldn’t be able to bond around common experiences. That’s just a falsehood ... they do just as fine as the other groups.”

“When you have somebody that was in Bosnia and all that ethnic cleansing that they witnessed, and you have someone in Afghanistan ... a couple guys in Vietnam, they get a full range of the uniqueness of their experiences and yet they all are able to look at the commonalities of how the trauma affected them. So it’s a very rich experience.”

In response to situations where tension between era cohorts arises, some programs have designated separated “tracks” for Iraq and Afghanistan veterans only or have added classes that address specific needs of younger veterans. For example, one program has a therapeutic recreation group specifically for younger veterans, another has an anger-based group, and another has an era-specific peer support group.

Discussion

Directors, providers and staff in 38 VA PTSD residential programs across the U.S. were interviewed as part of a quality improvement effort. Providers reported that in general younger veterans are different from the veterans from other conflicts, not only in obvious terms of age and recency of their deployment, but in regards to symptom presentation and treatment needs. Providers indicated that the intensity and comprehensiveness of Iraq and Afghanistan veterans' problems appears to have precipitated a shift in residential treatment culture and services. Providers reported that the challenges in treating Iraq and Afghanistan veterans in VA PTSD residential programs include acute PTSD symptomatology; other complex mental health symptom presentations; broad readjustment problems; and difficulty with time demands of and readiness for intensive treatment. Additional concerns included working with active duty personnel and mixing different eras in therapy.

The acuteness and intensity of symptoms in these returning veterans has necessitated a number of changes in programming. For many recent returnees, having recently been engaged in a physically demanding environment where physical training was an expected and necessary part of duty, the maintenance of a fitness regimen may help in the transition to a civilian life. In addition, regular exercise has been linked to a host of positive mental health outcomes including improving sleep and helping to relieve mild-to-moderate depression (Blumenthal et al., 2007; Thachuk & Martin, 1999).

Substance misuse is common across different war cohorts (Petrakis, Rosenheck & Desai, 2011). However, the current cohort of Vietnam veterans may have been in substance use recovery for a number of years before entering PTSD treatment, while younger veterans may be denying impact or severity of use or have only recently acknowledged misuse due to behavioral consequences (e.g., incarceration). Thus, for many young veterans substance misuse may still potentially interfere with treatment for PTSD and associated symptoms.

Along those lines, the providers noted a general increase in and access to prescription medications and chronic pain management problems. These findings are consistent with a large study showing that veterans with PTSD were more likely to be prescribed opioid painkillers and to use these medications in risky ways than other veterans with pain problems (Seal, Shi, Cohen, Cohen, Maguen, Krebs et al., 2012). In addition, Iraq and Afghanistan veterans with PTSD who were prescribed opioids for pain had a higher prevalence of overdoses, self-inflicted injuries and injuries caused by accidents or fighting. Some programs are exploring the feasibility of integrating chronic pain and PTSD treatment (Otis, Keane, Kerns, Monson, & Scioli, 2009) as well as looking for alternatives to opioid therapy such as exercise therapy and relaxation techniques.

Complexity in presentation also arises from concurrent and highly prevalent TBI. As such programs have made changes in their assessment and treatment. For example, screening for TBI has been included as a standard of practice in residential programs as the risk of TBI has substantially increased in the current wars. These numerous programmatic changes are being made for those with mild TBI and PTSD (Lew et al., 2009; Otis et al., 2009; Sayer et al., 2009). These include the use of personal assistive devices, slowed pace of treatment, longer length of stay and interdisciplinary collaboration.

At present, the recent returnees are expectedly younger than the current cohort of Vietnam veterans and are typically in a different life stage both developmentally (i.e., late adolescence or early adulthood as opposed to late adulthood) and in regard to life focus (e.g., beginning or rebuilding relationships and careers versus retirement, previously divorced or death of spouse). These findings are consistent with previous research on the reintegration problems and treatment interests among this newest cohort of war veterans

utilizing VA services (Sayers et al., 2010). In fact, almost 96% of these veterans expressed interest in receiving help to address a broad range of community reintegration issues (Sayers et al., 2010). Consistent with provider reports, others have also noted that treatment for these recent veterans requires addressing a broad range of psychosocial, rehabilitation, and functional problems (Batten & Pollack, 2008; Sayers et al., 2010). For example, Batten and Pollack (2008) advocate for the use of interdisciplinary clinical teams (e.g., primary care, vocational rehabilitation, mental health specialists) where care is not only concurrent but integrated to support treatment engagement, functional improvement and retention of gains in light of the multifaceted needs of these veterans.

Limited staff and time resources as well as remote locations were identified as barriers to integrating families in to residential PTSD treatment. One empirically-promising treatment that the sites may be interested in implementing is cognitive-behavioral conjoint therapy for PTSD as it has recently been applied to younger veterans and their wives (Fredman, Monson, & Adair, 2011). This treatment includes: 1) exercises to promote positive communication and development of conflict management skills, 2) behavioral interventions focusing on couple-level behaviors to improve dyadic communication and 3) cognitive interventions targeting maladaptive thought patterns that contribute to the maintenance of PTSD and marital discord.

Since many of the returning veterans are currently trying to return to school, maintain employment and housing, or raise young families, they appear to have difficulties in meeting the time demands required in intensive residential treatment. The utility of residential programming was based on the assumption that certain veterans responded poorly or insufficiently to treatment in outpatient settings and that there was a need for more intense and longer treatment. However, this conjecture does not always appear to apply to the population of newer returnees, particularly active duty service members who may benefit from treatment of acute symptoms, brief treatment, or a focus on readjustment and rehabilitation in conjunction with or in place of intensive residential processing.

Treatment of active duty personnel presents yet another complicating factor. There is a potential ethical dilemma in treating veterans who are most likely returning to active service, thus putting clinicians in a position of “dual agency” where they are serving both the patient and the organization’s interests (Stone, 2008). Provider peer consultation and support may be helpful in this regard.

Residential programs are also negotiating how to provide needed services for all combat eras. In regards to the mixing of veterans from all eras in treatment programming, older veterans can model for younger patients how to productively use the therapeutic process. Likewise, older, treatment-experienced veterans may be able to demonstrate to their younger counterparts the personal costs of ignoring psychological difficulties and unhelpful coping mechanisms and the positive role treatment can have across many domains. However, the incorporation of groups that specifically address unique developmental issues and those related to recent traumas may also have some merit. Optimal therapeutic milieu might include both attendance in blended-era treatment and additional groups limited to veterans of the current era and focused solely on those issues which are unique to their demographic group (Lyons & Swearingen, 2007).

While the findings are likely not surprising to providers who care for veterans with PTSD, the findings provide a nice summary of the observed differences between Iraq and Afghanistan veterans and those from prior generations who are currently seeking residential PTSD treatment. Those interested in service delivery such as managers and policy makers

should find these interesting and helpful in regards to understanding the field perspective on treatment of Iraq and Afghanistan veterans with PTSD.

This work has treatment implications for mental health providers who are responsible for treating veterans of different eras, with different exposure histories and needs. This kind of information can inform the design of programs and sharing of local solutions to commonly occurring service delivery challenges. It can also point out new directions for staff training and prompt development of new services and intervention components required by the different presentations of these newer veterans.

There are also implications for non-VA health care systems and individual providers. Studies of service utilization in this most recent cohort of veterans indicates less than half of returning veterans have engaged in medical or psychological treatment through the VA (VA Office of Public Health and Environmental Hazards, 2010). This suggests that large numbers of veterans likely receive treatment in non-VA settings by civilian providers, many of whom have limited understanding of military culture or trauma issues. Also, family members of veterans may likely seek assistance outside of VA for stress-related to veterans' service. Military service involves entry and participation in a unique culture, one which has a particular value set and cultural identity distinct from the civilian population. An understanding of military culture, including the benefits and challenges of serving one's country is likely needed to provide effective mental health care services.

Replication and extension of this work is clearly needed. Since the original purpose of the quality improvement effort did not include identification of the unique needs and solutions in working with recent returnees, a more systematic and structured inquiry would add value. It may be that there are additional clinical concerns for this population that were not mentioned often such as high risk for suicide (Jakupcak & Varra, 2011) and aggressive and unsafe driving (Kuhn, Drescher, Ruzek, & Rosen, 2010). Of course the identified problems may not be representative of all veterans seeking care. Other perspectives such as perceptions of patients and families might also add to these findings as well as draw attention to other sets of issues.

Solutions/Recommendations

Understanding VA residential treatment providers' perspectives regarding the unique challenges and developing solutions should assist in meeting the evolving needs of young veterans with PTSD. Assisting younger adults with distinctive problems with impulsivity, denial of illness, and eagerness to move forward with their lives is, as we have shown, intrinsically different from treating older veterans. A basic decision any treatment system will face in such a situation is whether to respond to impulsivity with efforts to exert control through restrictions and rules, or to adopt a philosophy of free choice in which even evidently "unhelpful" patient decisions are met with provider respectful disagreement but ultimate acceptance of the importance of learning from one's past choices. One possible approach to this dilemma is to take a long-range, harm reduction approach. Providers can never protect veterans from destructive choices, although some problems like suicidality, which are irreversible, must be met with insistence control. To address such problematic behavior with restrictions or external controls may result in a few short-term gains but less long-term learning. Fortunately for veterans, VA services will always be available in one form or another, and veterans can be encouraged to learn from their decisions and to regard treatment as a long-term process of learning and maturation. By supporting such reflection and such processes of learning staff may be of most help in the long run and may stand the best chance of avoiding alienating patients and thus potentially discouraging their future involvement in treatment. Recovery is best regarded as a long-term process with both

forward and backward movement in which the role of providers is to advise and guide in desirable directions.

The influx of Iraq and Afghanistan veterans entering into VA residential PTSD treatment has furthered program evolution from heavily psychotherapeutic and trauma-focused towards integrative care offering an expanded continuum of psychosocial and rehabilitation services. VA residential treatment providers have worked to accept the challenges presented by returning veterans to create opportunities to redesign their programs. Solutions have included increased partnerships with other services including rehabilitation, PTSD specialty clinics, nursing, substance abuse and local vet centers to broaden treatment teams and engage outpatient partners. This partnership with other services has also helped create a strong continuum of care to link veterans to outpatient services at the beginning of treatment with discharge planning that starts at the time of admission as well as when they complete rehabilitation treatment. Changes to recreation and nutrition have been necessary to move from an older, sedentary population to more active –focused sports offerings such as mountain biking, gym work-outs, and golfing for a younger group who need additional ways to decrease their intense affect as well as want to stay fit. Responses have also included increased training for staff members that include courses developed to increase understanding of military culture as well as training in treatments that are new to VA providers such as those to address family issues and co-occurring PTSD and substance use disorder. Changes have been made in medication management policies to address concerns about pain medication issues and new methods of addressing security and safety concerns have been developed. Residential programs are now much more flexibility in lengths of stay to meet differences in availability and veterans unique needs as well as new focuses on evening and weekend programming that allows inclusion of family members on the weekend or homework assignments that assist with treatments. All of these creative approaches have made it possible to move residential treatment programs to a more recovery-oriented, veteran-centered care model.

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Table 1

Unique Differences in Veterans' Residential Treatment Program Needs

	Iraq and Afghanistan Veterans	Vietnam and Other Veterans
Phase of Illness: PTSD Symptoms	Acute or "raw" PTSD symptoms complicated by other mental health problems Denial or minimization of substance misuse, including prescription medications	Chronic PTSD symptoms Recovery or remission of substance use disorders
Phase of Life: Psychosocial environment	Broad-based readjustment problems Potentially seeking employment Returning to school Living in non-permanent housing arrangement Repairing new marriages; Caring for young children	Permanently unemployed May have been divorced, separated or experienced long- term damage to interpersonal relationships with spouse(s) or grown children
Difficulty with time demands of intensive residential treatment	Difficult to commit to weeks of residential treatment due to family or employment responsibilities	Retired or disabled and able and willing to commit the time for intensive treatment
Hard to accept residential treatment and may not be ready for it	Acuteness of symptoms Few previous experiences with mental health treatment	Experience with mental health treatment
Active duty personnel	Unsure as to status of active- duty career; question whether they will redeploy	Not applicable
Mix veteran eras in programming	Can learn from older veterans about the long-term consequences of PTSD and avoiding treatment	Can provide mentorship to younger veterans Can see their younger selves in younger veterans

Table 2

Unique Issues of and Solutions in Working with Iraq and Afghanistan Veterans in VA PTSD Residential Programs

PTSD Symptoms are “raw” and complicated by other mental health problems
Case-by-case decisions when determining disciplinary actions
Inclusion of recreation and physical exercise
Greater coordination and collaboration with other medical and social services
Adjustment in patient goals
Longer length of stay or increase number of treatment sessions
Use of personal adaptive measures
Broad-based readjustment problems
Address interpersonal communication, couples or family therapy, psychoeducation for spouses, and parenting skills
Difficulty with time demands of intensive residential treatment
Flexibility in length of stay and structure
Hard to accept residential treatment and may not be ready for it
Utilize motivational interviewing
Use skill-focused shorter term “tracks” to provide skills and increase readiness
Active duty personnel
Address issues around possibility of returning to war
Address issues of confidentiality
Mix veteran eras in programming
Groups are era specific with integration in didactically instructed classes
Fully integration of eras in all programming
Mentorship: Pairing of older and younger veterans