Reintegration & Readjustment Program For Officers Returning from Deployment in Iraq and Afghanistan

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A true war story is never moral. It does not instruct, nor encourage virtue, nor suggest models of human behavior, nor restrain men from doing the things that men have always done. If a story seems moral, do not believe it. If at the end of a war story you feel uplifted, or if you feel that some bit of rectitude has been salvaged from the larger waste, then you have been the victim of a very old and terrible lie. There is no rectitude whatsoever. There is no virtue. As a first rule of thumb, therefore, you can tell a true war story by its absolute and uncompromising allegiance to obscenity and evil….You can tell a true war story if it embarrasses you.

The Things They Carried
Tim O'Brien (Author and Vietnam Combat Veteran)

It was a condition I first experienced after serving as a marine in Vietnam. I was never the same person after placing the first body in a body bag in Nam. And every day after that, there was just more death and destruction. I was changed; I was different from the man I used to be and there was nobody I could tell. I was afraid to talk because I was afraid to cry. If I started to cry, I might never stop. February, 1987

Officer Melvin Mason (Retired)
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Introduction

It is not uncommon for war veterans to experience combat-related posttraumatic stress disorder (PTSD) either soon after their return from duty or many years later. Police officers who are deployed for military duty present a real challenge for their respective departments as they return from active military duty to resume their law enforcement careers. The Metropolitan Police Department's Employee Assistance Program (MPEAP) has designed a primary prevention program for officers returning from the war in Iraq.

Although the symptoms of PTSD have been recognized for over a century, it was not until 1980 that the American Psychiatric Association designated the condition with its own diagnostic category. The symptoms result from exposure to a traumatic event that evokes feelings of *intense fear, helplessness, or horror.* (The diagnosis of PTSD can also

apply to any individual who has experienced a catastrophic life event like the 911 attacks, rape, and other natural and man-made disasters.)

The symptoms of PTSD include:

- Re-experiencing the trauma through painful, intrusive memories and recollections; suffering from nightmares and flashbacks. Reminders intensify the symptoms.
- Developing behaviors and attitudes that cause the person to avoid people, places, and things that may cause him/her to remember the trauma. The person may become emotionally numb with feelings of alienation from people, even those with whom the person had previously maintained a close bond. This can include family members, friends, and associates.
- Developing symptoms of irritability, impatience, anxiety, and depression. He/she may have a "short fuse" and is quick to become rageful with little provocation.
- Developing sleep problems and an ongoing feeling of hypervigilance and distrust.
- Experiencing problems with attention and concentration.
- Experiencing physical reactions like heart palpitations or sweating when reminded of the trauma.

The National Vietnam Veterans Readjustment Study (NVVRS)

The subject of combat-related trauma gained prominence in the aftermath of the Vietnam War. In 1983, the U.S. Congress commissioned a national study to examine the prevalence of PTSD and other psychological problems among Vietnam veterans. One of the largest, most comprehensive studies of its kind, the National Vietnam Veterans Readjustment Study (NVVRS) took four years and $9 million to complete. The study yielded the following results (*Trauma and the Vietnam War Generation,* 1990):

- The rate of PTSD for male veterans, in general, was 15.2% or 479,000 of the estimated 3.14 million men who served in Vietnam. For male veterans exposed to heavy combat, the rate was about 30%.
- The rate of PTSD for female veterans, in general, was 8.9% of the approximate 7,200 women who served in Vietnam.
- An additional 350,000 male and female veterans suffered from partial PTSD.
- The NVVRS also indicated a strong relationship between PTSD and postwar adjustment problems with veterans experiencing problems in every domain of their lives after the war.
- There was a substantially higher level of PTSD among minority veterans. African American and Hispanic veterans experienced more life adjustment problems after the war.
- Interviews conducted with spouses or partners of veterans revealed that PTSD had a substantial negative impact on the entire family, not just the veteran.
- The most important contributors to PTSD was the level of exposure (the more combat, the more PTSD), the veterans perception and interpretation of the

experience, and pre-war vulnerabilities like age of the veteran. The younger the soldier, the more vulnerable he was to PTSD.

- Another important risk for PTSD was the veteran's history of exposure to traumatic events prior to entering the military. More specifically, men with a history of pre-war exposure and were involved in heavy combat reported higher levels of PTSD than men with mo pre-war traumatic exposure who were involved in heavy combat. In essence, a kind of cumulative or "piling on" effect was noted in men who had been exposed to trauma before the war. (This finding is significant for police officers who experience multiple traumas as an everyday part of their work in law enforcement.)
- Characteristics of the veteran's family was also seen as an important etiological factor in the development of PTSD. Hence, if the veteran's family of origin was troubled, the veteran was at an increased risk for developing symptoms of PTSD.
- Research conducted by the National Center for PTSD noted that post-war stressors and losses in addition to the lack of family support placed the veteran in a higher risk category for PTSD.
- Factors associated with a healthier adjustment were reported by the National Center for PTSD as follows: The amount of support from family and friends; and the veteran's hardiness or resiliency (positive outlook on life).

The Persian Gulf War: Research Findings on Traumatic Exposure and Stress

The National Center for Post-Traumatic Stress Disorder, the Boston VA, The Tufts University School of Medicine, and the Boston University Schools of Medicine and Public Health released data concerning the effects of war-time exposure and outcome for veterans of the Persian Gulf War which ended in 1991. The war was brief, with limited troop engagement and few (non-Iraqi) casualties. Hence, most researchers studying the effects of the war have concluded that, except for some specialized units, PTSD rates among military personnel are lower than for most previous wars. However, units tasked with body recovery and identification showed the highest rates of PTSD. (One 1994 study by Sutker and colleagues found that nearly 50% of soldiers in a Reserve graves registration unit evidenced signs of PTSD eight months after returning. Most studies support the finding that the nature of war exposure weighs heavily in the development of full blown PTSD.

A noteworthy risk factor found by Engel et al. (1993) replicated findings in studies of Vietnam veterans with regard to pre-war traumatic exposure. Engel found that pre-combat traumatic exposure led to higher rates of PTSD. Several conclusions were drawn concerning post-war readjustment among veterans of the Persian Gulf War:

1. Increases in general distress accompanied by PTSD symptomatology were documented even in brief or circumscribed war experience.
2. There is a strong correlation between the intensity of exposure and psychological outcomes notwithstanding certain mediating factors.

3. Although there are several characteristics that contribute to the development of stress reactions, once PTSD symptoms occur, they are usually resistant to extinction particularly in cases of intense and/or gruesome exposure.
4. Researchers reported a "layering" effect of risk factors whereby inexperienced personnel and involvement with non-voluntary exposure were strongly associated with poorer outcomes, *over and above event severity.*

Treatment Findings

Treatment interventions that emphasized a comprehensive, multi-modal approach were found to be most efficacious. Preventive strategies like education regarding the impact of stress, family upheaval, and possible financial impacts were noted. Individual and group debriefings were seen as effective and necessary. Studies by Pennebaker and Harber (1993) found that talking about the events was widely beneficial and should continue well beyond the initial stages. This was replicated in a study by Ford et al. (1993) who found that problems in post-war adjustment extended over time especially where readjustment problems were experienced by the veteran's family or support system.

The MPEAP Reintegration & Readjustment Program for Iraqi War Veterans

Research findings on traumatic exposure and stress in Persian Gulf veterans and Vietnam veterans have provided education on the most efficacious programs to prevent or mitigate the degree to which PTSD, depression, alcohol/substance misuse, and other psychological problems interfere with an officer's quality of life and transition back to work and home. Direct interventions that focus on the officer and his/her family help to prevent family breakdown, social withdrawal and isolation, and occupational problems. The goal of the MPEAP's reintegration and readjustment program is to begin providing services as soon as the officer reports for return to full duty. By focusing directly on the officer's war experiences, traumatic reactions that interfere with his/her quality of life may be reduced.

Primary Prevention

A comprehensive program offered to the returning officer and his/her family is designed to

1. Facilitate a smooth transition back to work.
2. Provide counseling and education for the officer and his/her family.
3. Provide group counseling and education for returning officers to connect with each other.
4. Provide specific education on PTSD and potential problems encountered by returning combat veterans.
5. Provide training in anger management, coping skills, communication, stress management, conflict resolution, and parenting.

Strengthening Family Functioning Returning officers face many challenges as they prepare to re-enter their families. Families have undergone stress and changes in roles

with the absence of their deployed officer. These role adjustments need to be re-negotiated when the officer returns home. Because irritability, impatience, and tension are common residual effects of war deployment, family members often bear the brunt of the officer's readjustment difficulties. *The Transitioning Family Questionnaire* will be used to assess the extent to which the officer's family is re-organizing. The family and the MPEAP clinician can work together to identify potential problems. Couples who are at risk for domestic violence may be in need of immediate support. Ongoing counseling will help to reduce the intensity of feelings that can lead to unsafe behaviors. The MPEAP can provide a safe forum for discussing, negotiating, and resolving conflicts.

Co-Morbidity of PTSD with Alcohol (Ruzak, 2003). Education about safe drinking and the relationship between alcohol abuse and traumatic stress reactions is essential. Alcohol abuse adds to traumatic stress reactions and interferes with relationships, impairs coping ability, and the officer's ability to reintegrate and readjust into the world of work and home.

Overview/Treatment Philosophy

Validation of the veteran's war experiences is crucial to forming an alliance with the returning officer (Kirkland, 1995). Concerns related to family, friends, finances, physical health, and return to work can be overwhelming for the veteran who may need the therapist's help to sort them out and prioritize them. Pre-military traumatic exposure and post-military stressors play an important role in the readjustment process and deserves therapeutic intervention.

Central to the MPEAP treatment program is education about post-traumatic reactions to improve understanding and reduce fear and shame when symptoms appear. "Normalizing" feelings and teaching officers about the psychobiological reactions to extreme stress is crucial in mitigating the long term effects of their deployment experiences.

Training in coping skills like anxiety management, expressing positive feelings, and anger management will teach the officer *how* to engage in behaviors that are positive and helpful. With self-monitoring and practice the officer is empowered to make changes that are consistent with a resilient lifestyle.

Exposure therapy and cognitive restructuring in addition to traumatic stress education, coping skills training and family intervention form the basis for the MPEAP's comprehensive treatment program.

This article was published on the Gift From Within website in March, 2004.

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