In Search of A New Paradigm: Social Work for Twenty-First Century Veterans

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In Search of A New Paradigm:
Social Work for Twenty-First Century Veterans

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We do not need to believe in change. Change has already happened and is our new reality. The baby boomers who faced Vietnam must now confront the reality that Generations X and Y (Gardner, 2006) now face in America's ongoing twenty-first century conflicts, Operation Iraqi Freedom (OIF) in Iraq and Operation Enduring Freedom (OEF) in Afghanistan. In today's system of care for United States veterans, baby boomers are still in charge, managing national programs of health care for all veterans. Upon retirement, they hire new managers to maintain the same high standard of quality achieved in the Veterans Affairs health care system (VA). Yet these standards ensure the preservation of the VA approach to caring for veterans, an approach that, while successful, must be changed to meet the different needs of younger veterans. Young men and women returning from Iraq and Afghanistan stand in line for health care services with older veterans who know the system and know that the system knows them. Recognizing a need to address the specific concerns of younger veterans, the health care managers of the VA system have taken steps to guide veterans to specific services for OIF/OEF health care services, but much more needs to be done. Social workers must develop a new approach to health care if they wish to serve younger veterans effectively. Instead of a comprehensive review of our recently acquired knowledge concerning care for OIF/OEF veterans, the goal of this paper is to suggest a novel approach toward care for veterans that will maintain a high quality of care and recognize the unique needs of twenty-first century veterans. This paper shows how recent research findings have influenced the VA system to change mental health treatment methods with respect to the unique characteristics of twenty-first century veterans.

What do we know about twenty-first century health care consumers? Today, soldiers come to the military as volunteers. They often make their decision to enlist on the basis of their plans for an education or career or the needs of their families. They imagined the military and the battlefield as a school where they might learn important living skills and gain maturity. Upon return to civilian life, their hopes and expectations meet a brutal reality. In 2008, Lauderdale et al. discussed social work challenges for the twenty-first century and addressed the need for changes in our health care system. These authors expressed the belief that social workers need to continue their professional development by learning about the changing world around us and being engaged in a holistic approach to improve the quality of human life. In this respect, the challenges faced by contemporary medical schools as described by Smith (2009) are especially interesting. Smith criticized the old system of care as chaotic, with many different specialties and no one in charge of care for an individual patient. Smith described this as "episodic care," with a poor continuum of care. Smith said that a new system would develop in response to new discoveries in medicine and by an insistence on the application of evidence-based practices. He also noted that younger professionals, from Generations X and Y, would introduce new changes (Jovic et al., 2006). Regarding patient care, Smith acknowledged that former patients become young consumers who have a limited trust in older physicians. Such changes in the characteristics of those seeking treatment will impose adjustments on the healthcare system. The recently adopted VA Recovery Model of treatment (Kauth, 2006) is in agreement with Smith's conclusions that the new model for health care should be consumer oriented.

In contrast to America's treatment of soldiers returning from Vietnam, today's American socie-

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ty supports soldiers' participation in our military engagements and expresses a real interest in the well-being of OIF/OEF soldiers. This support, however, does not prevent the soldiers from facing struggles after they return. This new generation of veterans may have different needs and expectations of the health care system (Rosenheck & Fontana, 2007; Chard et al., 2010). We have already gained extensive knowledge concerning some health care problems of OIF/OEF veterans and begun to respond. Since the start of the conflicts stemming from the government's response to the events of September 11, 2001, there has been an interest in the well-being of deployed soldiers and the operations of the health care system supporting them. Hospitals that admit wounded soldiers have been converted to trauma centers. This conversion involves a change from an institutional structure with separate departments for different specialties to an integrated interdisciplinary system designed to serve poly-trauma cases (Elster et al., 2009; Brenner et al., 2009). Immediate need imposed a systemic adaptation to a new situation; in time, this new situation yielded new research data. This is exactly the process described by Smith (2009). The indispensable research of Hoge and his coworkers (2004, 2008) at the Walter Reed Army Institute of Research revealed that soldiers returning from conflicts today have a high prevalence of mental health diagnoses, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), anxiety, and depression. The high prevalence of TBI among OIF/OEF soldiers is very specific to the new kind of battlefield soldiers face, and has already forced the VA to create educational programs for professional staff concerning the recognition, screening, assessment, and treatment of veterans with a history of brain injury. In addition, treatment facilities have been built in the United States that can admit the wounded in about a week from the time of injury abroad (Elster et al., 2009). Health care providers have prepared the *Iraq War Clinician Guide*, accessible through the VA website (Dept. of VA, 2002/2011), and *Returning Home: A Guidebook for Service Members and Their Families* (Witzky & Padin-Rivera). In addition, results from the Millennium Cohort Study (Smith et al., 2011) and other research have led to

the formulation of evidence-based therapies for OIF/OEF veterans (Dept. of VA, 2011).

In the following section, the specific needs of returning soldiers are presented using the work of Litz and Orsillo (*Iraq War Clinician Guide*, Dept. of VA, 2002/2011, chap. 3) and other recent studies, with reference to selected data published by the Office of Public Health and Environmental Hazards, of VHA, from April 2011. These studies suggest the need for a holistic approach to the recovery of returning veterans.

Challenges of Returning Veterans

According to the updated 2011 roster of OIF/OEF and Operation New Dawn (OND, later name of Operation Iraqi Freedom) veterans, 1,285,651 veterans left active duty and became eligible for VA health care since 2002 (Office of Public Health and Environmental Hazards, 2011). However, only 51 percent of these veterans accessed VA health care. Most of our knowledge is gained from this group of returning veterans. The three most common problems diagnosed among veterans were related to musculoskeletal ailments, mental disorders, and "symptoms, signs, and ill-defined conditions." This paper is focused on mental disorders, which make up 50.7 percent of all diagnoses. Sources vary, but it is estimated that PTSD is diagnosed in 15 to 20 percent of the veterans who utilize VA services. Among those who utilize VA services, anxiety is diagnosed in 18 percent of cases and depression in 15 percent (Hoge et al., 2004; Stecker et al., 2010). However, these data are often questioned because the measurements are often taken using different methods, sampling selections, timing after trauma, and pre-deployment conditions (RAND, 2008; Richardson et al., 2010). The post-deployment environment also has a significant effect on recovery from chronic stress and traumatic events (Sayer et al., 2009).

We must assume the challenges of returning veterans as our own. A social worker confronting an OIF/OEF veteran for the first time must recognize the history of the person he or she encounters. Listening and understanding to each individual's history and matching it with our own professional training and what we know about how the-

se young people live is vital to successful treatment. This is why it is so important that we learn as much as we can about the environment of the battlefield and the struggles these young soldiers face before we meet with them. We are often just one of several professionals already assessing them, and they may have preconceptions about the treatment they are receiving. While listening to the veteran's story, we need to recognize what stressors had the most significant impact on the veteran's present situation. Veterans may start telling us that they were not well prepared for their experiences during war because of insufficient training, education, or even inappropriate clothes or equipment. The most significant stressors relate to combat exposure, incidents involving firearms, bomb blasts, the chaos and fear characterizing the wartime environment, and the powerful images of war-torn cities and broken bodies and lives. It is often impossible to differentiate civilians from enemy soldiers. Immediate danger can come from all directions and at any place and time. There is a constant perceived threat that is accompanied by the stress of uncomfortable living arrangements, a brutal climate, and the insecurity of shelter. This everyday stress adds to the traumatic experiences of combat, reinforcing the impact of these experiences on the brains and bodies of soldiers.

When assessing a veteran, we need to be aware that a veteran may be willing to tell his or her story and will expect to be heard. However, the veteran may also be very formal, as when talking with an officer. It is important to assure a veteran that he or she is in a safe environment and that health and well-being are our main concerns. A social worker needs to consider the veteran's immediate needs and expectations. We need to take a pre-deployment history, as many responses to stress and coping skills depend on the history of development in the stages of childhood and youth. In addition, any needs of the family and concerns about a work situation after deployment should be explored. Since the consequences of deployment may affect a veteran's life on several different levels, it is important to estimate how much family and social support a veteran may be able to achieve in his or her environment. When

assessment is completed, veterans need to know more about the next steps toward treatment process and recovery.

Wells et al. (2011) suggested on the basis of previous VA experiences that the number of OIF/OEF veterans seeking help at the VA will increase with time. Wells et al. noted that the VA already accommodated the inflow of new cases with specific characteristics by increasing the number of new mental health professionals about 8 percent. To ascertain appropriate treatment, the VA is implementing evidence-based treatment modalities for mental health disorders (Dept. of VA, 2011). In the case of PTSD, two modalities are provided: cognitive processing therapy (CPT) and prolonged exposure therapy (PE). Many new pharmacological therapies are tested and new medications are offered (Shad et al., 2011). The research methodologies are examined to ascertain that veterans receive the best treatment. One of the conditions that should be properly addressed before choosing treatment modalities is a history of stress and trauma in childhood. Nevin (2009) analyzed self-reporting data for the purpose of identifying pre-deployment mental health status. He found that this method has a low validity and postulated the application of an automatic screening system utilizing patients' electronic records. The pre-deployment history of trauma may implicate a risk of developing PTSD symptoms post-deployment (LeardMann et al., 2010). Another aim of research is the utilization and retention of VA services by OIF/OEF veterans. Seal et al. (2010) found that only one third of all veterans diagnosed with PTSD received any treatment in VA within the first year of post-deployment. The authors called for the development of new interventions to improve the retention of OIF/OEF veterans. There is a significant co-morbidity of mental health diagnosis, substance abuse (Seal et al., 2009; Jacobson et al., 2008), and physical symptoms (Cohen et al., 2009). This co-occurrence of mental health and physical symptoms is an argument for the development of an integrated approach of primary care and mental health services in the treatment of OIF/OEF veterans (McDevitt-Murphy et al., 2010). The abovementioned findings show how research con-

ducted in different areas has led to a new vision of VA health care. The center of this vision is a young veteran, who is looking for integrated help addressing all of his or her problems in order to rebuild a sense of security and hope in the future. We need to recognize all of the barriers that a veteran may encounter in his or her way when seeking help. Often, the symptom of a mental health problem (for example, fear of interacting with people) is the very reason the veteran delays seeking treatment.

New Trends in Research:
Post-Traumatic Stress Disorder

Research concerning PTSD in the first years of operations in Iraq and Afghanistan was concentrated on evaluating the prevalence of diagnosis among returning soldiers and causalities of this disorder. It was established that the most frequent causes for developing PTSD symptoms were experiences from a combat zone (Phillips et al., 2010). With more research, more questions surfaced. For example, there are two significant problems that may have an opposite impact on PTSD treatment in VA facilities. One is related to VA treatment resources and the other one to veterans' utilization of those resources. The beginning of a new conflict, increased news from zones of conflict, or just talking with OIF/OEF veterans in the halls of a VA facility may trigger trauma in Vietnam-era veterans (Rosenheck and Fontana, 2007). In addition, PTSD symptoms in Vietnam-era veterans may increase with age (Rosenheck & Fontana, 2007). This may explain why the VA is observing an increased number of PTSD patients with a history of trauma from involvement in previous military engagements (Rosenheck & Fontana, 2007). This influx of patients uses resources that otherwise would be available for OIF/OEF veterans. To be sure, the stigma of a mental health diagnosis (Vogt, 2011), barriers in service availability (Seal et al., 2010), insufficient social support, and poor treatment motivation (Sayer et al., 2009) remain factors that may decrease the utilization of PTSD treatment resources. This is why efforts are directed to both increase the kinds of resources available (Wells et al., 2011) and to improve the utilization of these resources (Seal et al., 2008; Brief et

al., 2011).

One of the clear differences between Vietnam-era and OIF/OEF veterans is the much higher number of women serving in the present military actions. Women are exposed to many stressors of the war, but their mental health concerns are related mostly to sexual trauma and non-combat non-sexual trauma. For these reasons it is suggested that group therapy for women should be developed and conducted separately from men (Fontana et al., 2010). The separate studies concerning men and women are part of a general trend of a diversifying population of veterans on the whole and OIF/OEF veterans especially. To learn more about one group of veterans it is important to be able to describe characteristics of that group and the specific problems they may have. This is why such diversification comes with more scrutinized research conditions and limitations. There are, for example, studies comparing the mental health issues of Vietnam-era and OIF/OEF veterans (Fontana et al., 2010; Chard et al., 2010), veterans from the conflicts in Iraq and Afghanistan (Hoge et al., 2004; Richardson et al., 2010), and veterans from different military branches (Phillips et al., 2010; Blow et al., 2011; Smith et al., 2011). Not all veterans respond to the same trauma the same way. Many studies address the risk factors for developing mental health problems (Phillips et al., 2010; LeardMann et al., 2010) and try to define protective factors (Jacupcak et al., 2010). Suicide, one of the most tragic and worrisome symptoms of mental health problems among OIF/OEF veterans, is the subject of special investigation (Jacupcak et al., 2010). Another concern involves traumatic grief (Pivar, 2002/2011). Grief related to combat experiences may complicate recovery from trauma. It is suggested that grief should be addressed before the application of more emotionally experiential treatment such as exposure therapy (Pivar, 2002/2011). This brief review of recent literature concerning mental health issues in response to trauma shows again the need to change the health care system, from a system divided into departments for different medical conditions to a system where the continuum of care is available whatever a veteran's specific status. This need is especially

evident when studying Traumatic Brain Injury.

Traumatic Brain Injury

TBI has been called the signature wound of OIF/OEF veterans, and much research has been devoted to this condition (RAND, 2008). One of the best resources for social workers is a study by Speziale et al. (2010) describing problems with the diagnosis and treatment of TBI among OIF/OEF veterans. There are many questions concerning the specificity of symptoms evoked by physical and psychological trauma. A physical injury to the brain may evoke symptoms that can be very characteristic to a specific area affected by injury. In addition, psychological and physical trauma may affect the Central Nervous System and evoke many generalized responses that are difficult to attribute to a single etiology (McAllister, 2008). The same event, such as a blast, may cause a physical brain injury and lead to the development of PTSD symptoms. An affected individual may develop symptoms of PTSD, TBI, and suffer from headache, depression, and sleep difficulties. These are all effects of disturbed brain functioning. It is important to appropriately diagnose all conditions and address them all in treatment and recovery (McAllister, 2008). Because of the overlap of symptoms for PTSD and TBI (Ruff et al., 2010), present screening instruments may overestimate PTSD diagnosis and may not recognize conditions of TBI (Sbordone and Ruff, 2010). One of the most common differentiating conditions for TBI is headache (Ruff et al., 2010). Like the research concerning PTSD, extensive research (Risling, 2010) on TBI leads to more distinct differentiations of TBI conditions. TBI incurred during military service is often different from TBI observed in the general population, and so these kinds of injuries have earned a separate name, BTBI, or blast-induced TBI (Cernak & Noble-Haeusslein, 2010; Hicks et al., 2010). This is an important distinction, because it addresses the larger spectrum of physical problems caused by the blast. The main difference is that the blast affects not only the brain but also the lungs and the entire body (Hicks et al., 2010). TBI often is followed by depression, anxiety, and substance abuse (Fann et

al., 2009; Brenner et al., 2009; Sacks et al., 2009). Although the relationship between TBI and substance abuse is not clear (Bjork and Grant, 2008), it is reasonable to assume that recovery from TBI could be significantly exaggerated by substance abuse. TBI may also be a factor in the poor behavioral control of individuals abusing substances (Starkstein et al., 2005).

The sequel of mental health symptoms of people affected by TBI is very challenging for health care professionals. Brenner et al. (2009) suggests that symptoms should always be addressed even if a proper diagnosis is a problem. Mood disorders, especially depression and anxiety, can be addressed by physicians with appropriate pharmacotherapy and therapists with special interventions (Speziale et al., 2010). The most common pharmacotherapy is the application of serotonergic antidepressants (Fann et al., 2009). Therapeutic interventions involve two behavioral approaches (Speziale et al., 2010): an operant neurobehavioral approach (ONA), and a relational neurobehavioral approach (RNA). ONA has elements of aversive feedback that may lead to anger and frustration which may create some challenges. However, this approach might be appropriate when change in behavior needs to happen quickly. RNA uses motivational interviewing as a form of negotiation between the therapist and a person with TBI, allowing the patient time for exploration and for finding a solution. A social worker who helps a person with TBI functions as both a therapist and case manager, exploring community resources, benefits, and the patient's family dynamics. In this way, the social worker assumes responsibility for the entire continuum of care (Speziale et al., 2010).

Anger and Violence

The most common symptoms of the aforementioned mental health problems are anger and violence (Elbogen et al., 2010; Kuhn et al., 2010; Teten et al., 2010). One of the most significant predictors of aggression is a diagnosis of PTSD (Teten et al., 2009). A PTSD diagnosis (Teten et al.; 2010, Finley et al., 2010) is associated with intimate partner violence as well as with other forms of power abuse like aggressive driving

(Kuhn et al., 2010). Basic training and experiences during deployment teach skills that are not compatible with family life. Veterans happy to come home soon encounter unexpected problems for which they are unprepared. First, they may experience symptoms of non-diagnosed PTSD or TBI or may have feelings of guilt, shame, grief, and confusion that they are not able to recognize and manage. They may have problems with communication and intimacy with an intimate partner. They may not be able to communicate their own emotions. Returning veterans who are parents often encounter problems reconnecting with their children. Besides family issues, the common problems of veterans are related to employment, recreation, and self-care. Litz and Orsillo describe these challenges in Chapter 3 of the *Iraq War Clinician Guide* (Dept. of VA, 2002/2011). Military families have a very specific culture of living in a high stress environment, with frequent geographic moves, high rates of service among women, multiple deployments, and increased risk of mental health problems. Sherman and Bowling (2011) reviewed studies concerning aid to OIF/OEF families. They cited statistics showing that three years after coming home 35 percent of families reported separation or divorce. The researchers described several therapeutic interventions that can be helpful in working with veterans' families. Most of them address anger management, communication, and emotion-focused therapy. Some of these interventions are short term, with only a five session curriculum (SAFE Program) or with 12 or more sessions; as in behavioral couple therapy, therapists use manuals with their patients to achieve desired outcomes.

Interestingly, according to some studies (Teten et al., 2009), PTSD is associated with non-sexual partner aggression and not with sexual aggression. We are aware that about 15 percent of OIF/OEF service women who received VHA primary care reported military sexual trauma. It is not clear how sexual acts of violence are related to mental health problems, as suggested by Kimerling et al. (2010). Power and violence are elements of military trainings. It is a problem when these learned skills surface in intimate partner conflict situations. Finley et al. (2010) described different types of domestic violence. One type, called patriarchal terrorism,

occurs when one person, usually a man, uses power and intimidation against the partner. The other type is described as a mutually violent relationship. While the first type is well known to all therapists dealing with domestic violence, the description of the second type comes from the work of Teten et al. (2009). According to these authors, 84 percent of men participating in a study reported that they experienced psychological and physical aggression from their intimate partners. It is important for social workers to recognize that intimate partner violence can be a part of the problems experienced by OIF/OEF veterans. It is also important to gain as much information as possible about the power dominance or vulnerability cycle (Scheinkman & Fishbane, 2004) in the different aspects of a couple's life. A social worker needs to be mindful that the stereotypical division between a perpetrator and a victim may not be the best way to understand partner violence among OIF/OEF veterans. It is much more appropriate to use models that may help partners to develop better communication skills, emotional control, understanding, and empathy (Sherman & Bowling, 2011; Scheinkman & Fishbane, 2004).

Another form of violence, suicide, must be discussed. The fact that veterans are twice as likely to commit suicide compared to non-veterans in the general population calls for special programs that would help veterans who may consider such an act of desperation (Kaplan et al., 2007). There are several hypotheses to explain this phenomenon. The most common is related to the finding that when a gun is present in the home, there is an increase in acts of suicide. Veterans often have firearms and they know how to use them. The other hypothesis associates suicide with the presence of mental health problems. Usually, studies evaluate risk and/or protective factors for the acts of suicide. A recent study by Jakupcak et al. (2010) showed that PTSD increases the risk of suicide. The same study also showed that married men and veterans with good social support are at a lower risk to commit suicide. A social worker working with OIF/OEF veterans must always assess a veteran's risk for suicide.

Stigma and Barriers to Care

Health care providers have access to a rich literature and treatment resources for returning soldiers and so they recognize well the mental health needs of OIF/OEF veterans. However, not all veterans who need mental health care actually seek treatment. Only 33 to 35 percent of those diagnosed with PTSD receive treatment and only about 10 percent of those in treatment went through the nine or more recommended sessions of therapy (Cohen et al., 2009; Seal et al., 2010). The most significant barriers to treatment, as cited in Brief et al. (2011), are related to beliefs concerning mental health and the availability of treatment. People are afraid of the label "mentally ill" and its effect on their social lives and careers. The general public stereotypes the mentally ill and these stereotypes shape returning soldiers' beliefs concerning the consequences of a diagnosis of a mental health disorder (Vogt, 2011). Veterans who are concerned with their military career are afraid that a mental health diagnosis will negatively affect them professionally. Some soldiers are afraid that their military leaders and comrades will accuse them of trying to avoid service in combat zones. They are afraid of being considered deserters. In addition, negative beliefs concerning mental health may affect the care received. Veterans often have problems with "talking" therapy. Soldiers have been trained to talk with authority figures in short forms and to not elaborate on their feelings and emotions. In this respect, the barrier to "talking" therapy is real.

One of the best ways to counteract this stigma is to involve primary care practitioners in screening and assessing mental health symptoms during medical intervention (Seal et al., 2010; Li & Sinha, 2008). In general, presenting mental health problems using medical terms seems to counteract stigma. Increasingly, literature for health care providers concerning PTSD and substance abuse uses more and more terms adopted from neuroscience and general medicine. It is not enough any longer to say that substance abuse is a disease. Today, we discuss the inhibitory control of emotions by the prefrontal cortex, body stress response, and the action of the reward center (Li &

Sinha, 2008). Exposure to violence in childhood will no longer suffice for a complete explanation; instead, we refer to the genetics of anxiety and trauma-related disorders (Norrholm & Ressler, 2009). Practitioners adopt these terms in a well intentioned effort to avoid causing feelings of guilt and shame in people affected by PTSD and substance abuse. We know that these feelings may exacerbate mental health symptoms. We can protect our clients from experiencing these feelings by teaching them about the latest achievements in the medical field. Some mental health symptoms can be easily addressed by primary care practitioners during a medical exam. One such example is addressing sleep problems such as insomnia, nightmares, or sleep apnea. Addressing the quality of sleep is very important because sleep problems can aggravate many health conditions. In addition, nightmares may lead to the development of PTSD by disturbing sleep-dependent emotional memory integration (Picchioni et al., 2010). Biological approaches may also help us to conceptualize depression (Milton & Gillies, 2007). Depression can be seen as helplessness, as a disengagement from the part of life that is not working. Using such biological approaches to battle the public stigma associated with mental illness is just one step in devising a treatment plan that will improve the health of veterans.

In addition to the stigma from the general public, internalized stigma may affect mental health, leading to depression, low self-esteem, and a lack of motivation. Brown et al. (2010) showed that people who battle one stigma can be more resilient to the effects of different kind of stigma. For example, an individual who has managed well the stigma of race may be less affected by the internalized stigma of depression. Procrastination, or a lack of motivation, may also be a barrier to seeking treatment for mental health problems (Stead et al., 2010). Stress reinforces procrastination; as a result, those who need treatment the most are the least inclined to seek help.

To overcome treatment barriers, the treatment offered must be attractive and hold out the promise of being effective. The best way to accomplish this is to offer treatment in the veteran's own en-

vironment and to utilize the veteran's strengths. An example of this kind of approach is an intervention called Battlemind Training, available on military sites online. Battlemind Training uses the skills soldiers learn during basic training and on the battlefield to teach them how to cope with trauma. Such online resources may offer significant help in overcoming several other barriers to treatment.

Web-based Interventions

More than 50 percent of OEF/OEF veterans live in rural parts of the country. The most important barrier to treatment, then, is simply distance to health care. In addition, many veterans work full time and report problems associated with scheduling appointments and managing their time for work, therapy, and family life (Iversen et al., 2011). Compounding the problem, evidence-based therapies are not widely available and, due to the structured program of these therapies, scheduling is not very flexible (Brief et al., 2011). As a result, health care providers are increasingly turning to web-based interventions. Younger OIF/OEF veterans are more accustomed to using the internet in their daily lives (Gardner, 2006), and so this approach has the potential to reach a greater number of those in need. Additionally, web-based interventions can be used anonymously, from home, and at a time convenient for veterans. In general, these interventions consist of elements of motivational enhancement and cognitive behavioral strategies. Their goal is to involve the veteran in the work of treatment and recovery as soon as possible because early intervention yields the best results. Without such intervention, acute symptoms may become chronic disorders, especially when veterans learn to self-medicate with alcohol and other drugs of abuse. One example of a web-based intervention is *VetChange* (2010), an online service that helps men and women cope with the symptoms of PTSD and substance abuse (Brief et al., 2011). Another online resource is Interapy, offering treatment for PTSD with education, trauma-focused writing assignments, and cognitive restructuring (Lange et al., 2001). Amstadter et al. (2009) have reviewed such internet based interventions, and Rizzo et al. (2011) have described applications of virtual reality. In addition, separate online programs aim to

help those affected by TBI. The most well known are websites with brain games (*Lumosity*, 2011) that can help veterans with a brain injury to improve memory and attention.

Treating Symptoms vs. Finding Meaning in Life

The generation born between 1976 and 1994 has been described as optimistic, hard-working, civic-minded, and easily adapting to change (Gardner, 2006). The majority of soldiers returning from Iraq and Afghanistan are returning in good health with no mental health symptoms. Some of them continue careers in the military while others continue civilian education or look for employment. Their life decisions are based on their life experiences. In contrast, veterans with mental health symptoms struggle when making these decisions. Very often they have dreams and expectations of the future that seem not to be attainable. Some of them decide to go back to the battlefield because civilian life "doesn't make sense anymore" (Pitchford, 2008). Pitchford (2008) discussed the existential dimension of the effects of war trauma on Iraqi soldiers. He applied the existentialism of Rollo May in a study of veterans' perceptions and their understanding of their life experiences (Pitchford, 2009). There is not much literature concerning the application of existentialistic therapy in the treatment of OIF/OEF veterans. Though only evidence-based practices are accepted in health care systems such as the VA, it is important to show that other treatment modalities can be helpful as well. Pitchford (2008) made an attempt to offer evidence that his existentialistic approach is appropriate in treating anxiety disorders including PTSD, reminding us (Pitchford, 2009) that May postulated that existentialistic psychology can connect science with an individual's real life experience. Pitchford applied several concepts of the therapeutic approach to his integrated method (Pitchford, 2008) with the application of existentialistic therapy. One concept is that symptoms of anxiety are considered to be the result of a threat toward an individual's values and sense of security. The treatment of anxiety happens through the therapeutic relationship between the veteran and the therapist.

The first goal of therapy is to establish a level of safety and trust that allows the veteran to take a risk in exploring his experiences. The client's anxiety can be used to motivate for further work for growth and learning about self. Pitchford claims that a veteran in treatment wants to reconnect with the person he or she was and the person he or she is becoming. The concept of freedom stands for clients making their own choices and experiencing how life affects their choices. Recovery happens when a client develops a stronger sense of self. Otherwise, the client may continue to experience a loss of meaning – the main reason the client sought treatment after trauma in the first place.

King (2008) studied the relationship between pessimistic attitude measures and meaning in life with the scores of PTSD symptoms among veterans. Her study suggested that the best therapies for veterans should address cognitive and unconscious processes that alleviate feelings of hopelessness and restore meaning in life. Whitesell and Owens (2011) studied the role of morale as a risk factor for PTSD. They found that higher morale is a protective factor against the development of PTSD. A nice review of all available treatment modalities for veterans is provided by Day (2009). Among many other approaches, Day discussed narrative therapy. When veterans are asked what they need the most, they respond that they want somebody to listen to their stories. Narrative therapy can be integrated with existential intervention that could help veterans to explore the world around them. Another possibility is integrating a motivational approach into existential therapy (Odde, 2011) based on the veteran's need to reconnect with self. There is a fundamental difference between a generally accepted treatment modality such as cognitive behavioral therapy and a new approach such as existential therapy. The goal of the former is to minimize the symptoms whereas the goal of the latter is to create a more deliberate way of life (Claessens, 2009; van Deurzen, 2009).

The experiences of veterans in combat zones are not compatible to civilian life. Because of these experiences, veterans need our help making the transition to civilian life and developing new lives in remarkably changed circumstances. This review of recent publications in the field of mental health problems of OEF/OIF veterans has shown that veterans need professionals with a proper understanding of the causalities and treatment of brain and mind disorders. Veterans need guidance through the process of healing and reconnecting to self. This is a process that happens in the course of developing a therapeutic relationship between a provider and a veteran (Koloroutis, 2004; Pitchford, 2008). Veterans empowered by hope and trust in their own abilities (Kauth, 2006) will explore the meanings of their lives and take risks in the world to which they have returned. One of the most difficult challenges to meeting such a goal is continuing education in colleges and other institutions of higher education. Many colleges have developed special programs designed to help new veterans to accommodate to the role of a student (Ackerman et al., 2009; Flynn & Hassan 2010). This additional training may make a significant difference in the veteran's future. We need to walk with the veteran through life's transitions in order to help the veteran understand his or her past, present, and future. Younger social workers, those from Generations X and Y, may offer more effective help to returning veterans. These social workers must understand both the facts of war and the latest research in order to help veterans adjust to the brutal reality they face upon return.

Summary

This paper presents recent efforts to describe the mental health needs and best treatment practices for veterans returning from Iraq and Afghanistan. The primary mental health problems of returning veterans are symptoms of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), anxiety, and depression. New research advances divide the population of veterans into specific groups with individual needs in an effort to better customize treatment intervention. Both primary care and web-based online treatment modalities have been developed to improve the utilization of mental health care. The present treatment modalities have been designed to minimize the symptoms of mental health disorders, but,

recently, more studies have encouraged the development of a holistic approach to help veterans understand the meaning of their traumatic experiences. This is achieved by building a therapeutic relationship with the application of existential therapy. This paper offers social workers necessary information to build a relationship-based practice with a new generation of veterans.

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