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Hi. Today we're going to be talking about understanding the context of military culture in treating the Veteran with PTSD.

My name is Patricia Watson I work for the National Center for PTSD at the Executive Division and I also am an assistant professor in psychiatry at Dartmouth Medical School. I also have had eight years of experience as a clinical psychologist in the Navy.

Our learning objectives today are to become familiar with military terms as well as demographics in the current military, to describe some of those stressors that active duty members may experience while in the military, to describe programs that are offered by DoD for dealing with combat and operational stress across the different branches, and to discuss some of the implications of military culture for VA clinicians working with both active duty members as well as Veterans.

Now to go on to military demographics, while gender, diversity, and job types are always changing in the military, I want to give you a general idea of recent numbers in these areas so that when you're working with service members or Veterans, you have a sense of what kind of environment they've been working in.

In fiscal year 2006, women represented about 15 percent of the Active Component and 17 percent of the Reserve Component in the military. However there is always a lower proportion of women in the Marine Corps—approximately six percent—mostly due to the higher proportion of combat arms positions, which precludes women from serving in those units. Now this may change in years to come as more and more women are requesting to be deemed qualified to serve in combat, but at this point it stays at about six percent.

In terms of race and ethnicity, currently racial minorities constitute approximately a third of Active Duty forces and a quarter of Reserve Component forces. While representation for service members who are black, American Indian, or Alaskan native, as well as native Hawaiian and Pacific Islanders is parallel or exceeds that of the civilian sample, the percentage of Asian and Hispanic individuals in military service is lower than that found in the general population.

As for job type, the military requires an adequate number of members who serve in combat and combat support positions but there are a wide variety of jobs available depending on skills and interests. In fiscal
year 2006, about a third of all Active Duty enlisted members were in occupations such as infantry, craftsman and service and supply handling while the majority—around 43 percent—served in mid-level jobs in medical and dental or functional support and administration or electrical mechanical equipment repair. The remainder—about 25 percent—were in high skill areas like electronic equipment repair, communications, intelligence and other specialties or in the non-occupational category.

To cover military demographics, I am including information about the different branches of the military, the rank structure in the military, and the military specialty using MOS or NEC. You can hear about any or all of these topics by clicking the related button on the screen or, if you're well versed in military demographics, you can skip to the next section.

Additionally, if you'd like more in-depth online training on military cultural competence, I encourage you to click on the link at the bottom of the screen, which will take you to an excellent site designed by the Center for Deployment Psychology.

To begin with, just to start with military branches, as you’re working with service members, you would want to know how to refer to them. So for instance, if you're working with an Army personnel, you would want to know that he is referred to as a Soldier, and an Air Force personnel would be called an Airman. If you're working with Navy personnel, they are referred to as Sailors, and Marine Corps personnel are referred to as Marines. Finally, Coast Guard personnel are referred to as Guardians. However, as you're working with service members, it's most important to find out from them how they would like to be referred to. So you would want to ask him first whether or not they want to be called by this title or by their rank, or if they're newly separated from the military, by Mr. or Ms. Whichever is most comfortable for them is the way you want to refer to them.

Each branch of the military has a different function and purpose, as well as a unique culture of its own. To start with, the Army is the oldest and largest of the military services. It represents the main ground force for the United States. The Army is comprised of an Active component as well as two Reserve components, the Army National Guard and the Army Reserve. The Army has a proud tradition of being the oldest and largest service and has a natural rivalry towards the other services, particularly the Navy and they have a lot of rivalry in their football games as well, as many of you might know.

The Navy is the second largest branch of service and is composed of both Active and Reserve components, but doesn't have a National Guard. Their primary mission, rather than being a ground force, is to maintain, train, and equip combat-ready naval forces. In addition, they also play an essential role in augmenting air power and transporting Marines. So the Navy also assists the US Marine Corps with personnel, support, and supply.

The United States Marine Corps mission is both seizure and defense of advance naval bases and other land operations that support naval campaigns, as well as other duties the President may direct. So, for instance, their role in Afghanistan currently is not necessarily a Marine function on sea but rather more of land force. Administratively, Marine Corps is a component of the Department of Navy, but it acts operationally as a separate branch of the military.

The Air Force is the youngest of all the military services and, as its name implies, it represents the aerial warfare branch of the armed forces. The Air Force is composed of an Active component and two Reserve components: the Air Force Reserve as well as the Air National Guard. While the Army, Navy, and Marines all have and utilize aircraft, it remains the mission of the Air Force to fly, and to fight in air space, as well as in cyberspace.

And finally, the United States Coast Guard is an armed force but it differs from the rest in that it's not a part of the Department of Defense but rather falls within the Department of Homeland Security. The US
Coast Guard's mission is to protect the public and the environment and the United States economic and security interests in any Maritime region.

Military structure encompasses both rank as well as specialty. The military is comprised of three general categories of rank that included enlisted, warrant officers, and commissioned officers.

Enlisted personnel generally have a high school diploma or equivalent. However, many have or are actively working towards higher degrees. As enlisted personnel progress up the ranks, their leadership responsibilities increase significantly and this responsibility is recognized by the use of terms noncommissioned officer and petty officer. Or, you may hear enlisted members referred to by their pay grade such as E-1 or E-6. These pay grades are the same across services although the corresponding rank might have a different name.

Warrant officers are highly specialized experts in specific career fields. Their purpose is to provide specialized knowledge and instruction in their primary specialty, for instance, pilot. And, a warrant officer does not focus on increased levels of command and staff duty positions like commissioned officers who are generalists. There are no warrant officers in the Air Force and warrant officers make up approximately two percent of military personnel. So, it's a fairly small percentage.

Finally, in general, commissioned officers have a minimum of a four-year bachelor's degree and many have advanced degrees as well, such as Master's degrees. The commissioned officer ranks are highest in the military. They are similar to managers or leaders in a company. And, these officers hold presidential commissions and are confirmed by their ranks in the Senate.

Army, Air Force, and Marine Corps officers are called company grade officers in the pay grades of O-1 to O-3, field grade officers in pay grades O-4 to O-6, and general officers in pay grades O-7 and higher. The equivalent groupings in the Navy are Junior Grade, Mid-Grade, and Flag. Commissioned officers generally do not specialize as much as enlisted personnel and warrant officers. And as an officer moves up the ranks, he or she gains more experience in different areas with the ultimate goal of taking command over more and more troops.

Now on the MOS/NEC side, MOS stands for Military Occupational Specialty, and in the Navy, NEC stands for Navy Enlisted Classification. This is the job that an enlisted service member typically does. So, when you’re assessing a service member, it's good to ask them both what their rank is—or if it's a Veteran what their rank was—as well as what their MOS or NEC is if they are enlisted. This will give you the most information about where they fall both in the rank structure as well as specific duties they have had to perform.

To download a convenient military ranking chart, click on the button below that you can print out and put on your desk so you are very comfortable and familiar with the different structures in the military.

In terms of military status as you're working with service members in the military, it's important to know about their status, including Active Duty, National Guard, Reserve, or Individual Augmentee. So, if you have a service member presenting who has primarily been on Active Duty. Active Duty itself has its own stressors. An Active Duty member is considered full time, working 24 hours a day, seven days a week when they're on deployments, which can tend to be anywhere between six to 15 months. And when we're in a wartime environment, in between deployments Active Duty members have a very strong training cycle, which means that even though they're not deployed, they are still having separations from their families as a result of long hours of training.

National Guard members and Reservists have a different set of stressors that might impact their presentation to you. Both National Guards and Reserves generally tend to come from an environment of
operating in a capacity of part time, usually 39 days a year. They come and do drills and they're considered part time employees. However, in situations such as we've been in with wars, they are sometimes very unexpectedly and quickly called into Active Duty. Because of that, they're often moved out of jobs and lives, and moved across the country or onto deployments right away—away from their families and communities. When they return from Active Status, rather than coming back home into an Active Duty environment that has a lot of support system, sometimes they might just be sent right back to their home environment, and they don't tend to have the support system around them that Active Duty members do. So that has a whole different set of stressors for them that can compound any presentation of PTSD.

And finally the Individual Augmentees are generally service members who are Active Duty but they're pulled out of their home unit and transferred to another unit or another branch of the service as a result of their specialty. So, these are people who are pulled up to fill shortages or are used in areas where their skill sets are required, and it could be that, for instance, they're in the Navy but they're transported to somewhere away from their home unit to work for the Army. And so Navy and Air Force personnel, generally right now, there are about 12,000 Navy and Air Force personnel filling Army jobs. And then there are personnel within the branches who are filling jobs away from their home units. This can be very stressful in the sense that they also don't have their normal support system around them. And the Individual Augmentee tours can be very capricious, where they're pulled up quickly and are sent away, and they get to come back, and have to go out again fairly quickly. So it's a whole different set of stressors for Individual Augmentees.

OK, so we've talked about military structure and military terms, as well as military demographics. Now we're going to move into talking about specific stressors that occur across different military branches.

So, in terms of different stressors in the military, they can fall within a number of different categories, and I just want to mention a few of the more obvious ones. The first is life threat, which can occur as a result of exposure to lethal force or its aftermath in combat situations. It can also occur in operational situations where there's a higher expectancy for accidents and that type of thing. And this is a very obvious common impetus for PTSD diagnosis, when somebody is exposed to life threat.

The second stressor that is very common in the military is loss. This can occur due to the death of close comrades or leaders, or other individuals. Or, it could be a different type of loss, like the loss of relationships that occur when individuals are separated for long periods of time. Loss of different aspects of oneself, such as functioning when there's an amputation or an injury. And the loss of possessions, when people have to move across different areas across the course of their career.

The third is inner conflict. This occurs when people have a sense of conflict with their belief systems or values. And in the military, this can be something that can be particularly problematic. I've spoken with a number of clinicians who've indicated that this of all of the precursors to PTSD is one of the more challenging ones—when people feel a sense of guilt and shame as a result of carrying out or bearing witness to incidents that violate their deeply held belief systems.

Next, is the issue of wear and tear. So, operational stress occurs when people have ongoing adversities over a long period of time where they're away from family, where they're not sleeping well, where they're not eating well, where they're not able to rest and restore themselves. And all of these stressors occur in the context of an environment where there's a very close scrutiny on behavior, very high expectations for military bearing, military values—where a person is meant to be strong and fully operational at all times. So because of these expectations, as well as the contractual agreements within the military where people serve long courses in their contracts, many people have indicated that they feel they have to behave and act in a certain way. There's a strong stigma associated with receiving mental health care in particular, and there's also a sense that they can't take a break or back away if they need to back away because
they're obligated to their contracts. So, it can be a very challenging confluence of factors that lead a person to having PTSD or different types of stress responses.

Military sexual trauma is another very common traumatic stressor in the military that causes great stress in military members. In a few recent studies, both with Active Duty personnel and Veterans—I want to give you some numbers on this—with Active Duty personnel with a reference to the past year of service, there were very high numbers of offensive sexual behavior reported. About half of women reported this and about a third of men reported offensive sexual behavior. There's also unwanted sexual attention being reported by a third of the women and about 7% of the men. There is sexual coercion being reported by about 10% of women and 3% of men. And finally, unwanted sexual contact being reported by about 7% of women and 2% of men. And when you look at lifetime prevalence in a VA population, about 20% of women and 1% of men report military sexual trauma.

So across a range of studies, people are reporting either sexual harassment or assault in the military. And this is important for VA clinicians because this type of stress, this type of trauma for people, is associated with more mental health problems, more physical health symptoms and conditions, and more problems adjusting after discharge. Military sexual trauma has a much stronger, more lasting impact on both service members and Veterans above and beyond sexual assault on civilians. It's related to more distress, mental illness, lower physical health, lower self esteem, more severe PTSD symptoms.

We think this is because it's an interpersonal trauma; it's perpetrated by someone who was presumably supposed to be protecting your life. And, it may not always be possible to report the crime for a variety of reasons. What I've heard from service members is that they feel obliged to keep quiet so as not to either be blamed for what happened or to reduce morale in the Company or to have this impact their career in one way or another. Finally, it's often coupled with other types of adversities or exposures to trauma. So, it can be a very challenging stressor for people to deal with.

Because of this, in the Department of Veterans Affairs all users of VA health care are supposed to be screened by a health care provider for experiences of MST. So you should be asking whether or not they've been screened. And in addition, you should be asking the questions about military sexual trauma. We have a very good PTSD one-on-one module on military sexual trauma if you want to get more information about this very important topic.

Based on your experience, which factor do you think has the strongest impact on mental health status? Do you think it's level of combat, the length of deployment, or the number of deployments a service member has had?

The mental health task force assessments have been deployed to Iraq every year since 2003 and the findings are used to allocate resources to better meet the mental health needs of service members. So, the findings from the most recent surveys in 2007 and 2008 include that the level of combat seems to be the main determinant for mental health status. Deployment length and family separation were the top noncombat issues reported by service members. They are reporting much longer deployment lengths and more frequent deployments, and this is having an impact on their family time as well as family quality of life. Marines are reporting that they have fewer noncombat deployment concerns. And this might be due to the fact that they have shorter deployment lengths than the Army.

Soldiers reported higher rates of mental health problems than Marines. However, when you match Soldiers and Marines for deployment length and deployment history, the Soldiers’ mental health rates were similar to those of Marines. So, it's probably not that Soldiers have more likelihood of mental health problems. It's probably about the way that they're deployed, the length of their deployments, as well as their exposure.
And then finally, Soldiers and Marines with mental health problems were more likely to mistreat noncombatants. So, we’re seeing some level of changes in their moral beliefs and values in terms of the way they’re acting out toward noncombatants.

For a more detailed report on this, you can click the link below for the final report of the impact teams.

The DOD has recently reported on rates of mental health issues from 2003 to 2007. From the Mental Health Assessment Team findings, the rate of self-reported PTSD, which is defined as at least a score of 50 or greater on the PTSD checklist, was coming in at about 14 percent with annual prevalence rates which range from 11 to 17 percent. The prevalence of screening positive for either PTSD, depression, or anxiety, again using self-report instruments, was 16 percent across the five-year sample, and the annual rates range from 13 to 20 percent.

It’s also important to keep in mind that of the service members who screened positive for mental health problems, more than half every year reported that they would not seek care from any source, specifically because they didn’t want to be seen by others as weak if they did. So stigma is a very strong barrier to receiving mental health care.

Other evidence for growing mental health burden in the military is coming from the post-deployment health assessments and post-deployment health reassessments that are required at end of deployment as well as 90 to 120 days later. We’re finding that about 40 percent of Army Soldiers and 30 percent of Marines are reporting significant mental health problems between 90 and 120 days post-deployment.

The DOD has also returned findings on family mental health and family functioning, which I think are very important when you’re working with service members.

In the Mental Health Task Force Survey from June 2007, they reported that strains are being reported by family members, including divorces and family violence, and that these concerns are most often related to deployment length. Overall, their marital satisfaction seems to be high but marital problems are increasing. So, if you look at the OIF I survey about 12 percent of service members reported marital problems. That increased in 2004 and 2006 among Soldiers to 22 percent and 2005 to 2007 in Soldiers to 27 percent and Marines to 23 percent. So we’re starting to see probably the impact of wear and tear and long-term stress on these families.

The Mental Health Task Force findings also reported that families are crucial for the recovery of wounded Soldiers. They are starting to build them into the rehabilitation program that family members help service members gain a sense of structure, organization, and socialization. For Traumatic Brain Injury (TBI) service members, they're finding that families can help them much more rapidly recover as a result of interacting with them in certain ways. Families are also being reported as very strong partners in developing psychological health. They are often the first ones who report that a service member has changed and recognize stress in service members. Often, they're the prime motivator for service members to get help and they often are crucial partners in promoting mental health service for service members. So it's important to keep this in mind as you work that family members need to be folded into your treatment and assessment.

We’ve talked about military terms and structure as well as different stressors that service members are reporting. Now we’re going to describe programs that are offered by DoD for dealing with combat and operational stress.

You will find that all of the services are offering many different selected interventions for building resilience in their service members. A core piece of all branches of the service is basic training and realistic training. So what they try to do is build up a sense of stress inoculation in their basic training.
They have high stress situations where individuals are either screened out or they are made stronger through these realistic training experiences and make service members feel more prepared for their duties.

In addition to that, there's a very broad safety net that includes family service centers, life skills training, as well as mentoring. So, different services will focus a little differently on each one of these. But there are multiple services offered for family counseling, family planning, budget planning, and all different types of life skills training. There are warrior training programs across all the different branches of service and there are mentoring programs so service members can talk with leaders and people who have achieved a greater sense of resilience and can model after those. The goal is to get service members feeling more like they have a sense of self-efficacy, that they can achieve in their career, as well as handle stressors in their environment. We're going to talk more specifically about Battlemind as well as the new Army Resilience Training Program and the Marine Corps Combat Operational Stress Continuum Model.

We are going to talk about the Army Battlemind and Marine Corps Combat Operational Stress Continuum Programs. Choose the one you would like to know about first.

In Army Battlemind training, the term Battlemind is equated to inner strength and the two key components of this inner strength are said to be self confidence and mental toughness. So, in the Army model, each of the ten Battlemind skills or challenges is presented as a choice the Soldier can make between a maladaptive behavior or attitude and an adaptive one.

So, each one of these steps has a choice about whether or not you’re going to stay in the mode that you were in when you were deployed or find a way to adjust and become more resilient in the family and home environment when you return.

So, they have it spelled out in an acronym of “Battlemind” for service members to be able to remember. And, they're things like reminding themselves that when they're in a deployment situation, the cohesion of being with buddies might also make it more difficult to be with family members and friends when you come home. You might find yourself withdrawing. So, you have to find a way to adjust and instead of withdrawing, becoming more involved and connected with your family members. Accountability—you may find that in the service member environment that you have such a strong sense of accountability and threat, that everything has to be done perfectly in order to reduce that threat. That the counterpart when you're at home is that you're controlling and you have to find a way to adjust for that when you are back in a civilian environment with family and friends.

Battlemind includes no provision for screening, for symptom severity, or tailoring different prevention strategies based on symptom burden. It's really geared more towards having the power within themselves to control different signs or symptoms. And so it puts a large percentage of the burden on the Soldiers themselves to find a way to be strong both in a deployed situation and a non-deployed situation. The training modules for Battlemind occur in both pre-deployment as well as in the transition from combat to home and then later down the road there’s a second Battlemind training for continuing the transition home. They also include a component of Battlemind psychological debriefing that's similar to critical instant stress debriefing but includes education about the Battlemind acronym.

The Army has additionally announced recently a plan to put together a very large program called the Comprehensive Soldier Fitness Program in collaboration with University of Pennsylvania. The goal is for this Comprehensive Soldier Fitness Program to enhance the physical, cognitive, social, and spiritual fitness of every Soldier and family member in the Army and they're going to bring in principles of cognitive behavioral intervention such as changing thoughts, or reframing thoughts, in order to put this in place in the Army system.
The Marine Corps Combat Operational Stress Continuum is part of their new doctrine that’s been put into place in the last year regarding combat and operational stress. The stress continuum model calls for a deployment cycle training for Marines that includes Warrior Preparation 30 days prior to deployment, Warrior Transition that’s usually within seven days of returning home, as well as Warrior Transition 2 that’s delivered 60 to 90 days post deployment. It also includes a lot of leadership tools that are put into place in the Navy as well as Marine Corps, including After Action Reviews—which are small group discussions to promote social support and review what has happened/lessons learned, that type of thing— individual or unit rest or rotation, memorial services, as well as ceremonies and celebrations.

Now the Stress Injury Continuum Model was developed by Marine Corps and Navy medicine based on some evidence-based and evidence-informed principles that are congruent with the Navy/Marine Corps culture. So, it has four stages including: Ready, Reacting, Injured, and Ill. And the model highlights a shared responsibility that both Marines as well as leaders have for protecting force readiness.

So, in the Readiness Zone, this is really considered a leader responsibility to make sure that your service members are trained up and ready to go.

The Reacting Zone acknowledges that a hundred percent of the people who are faced with very stressful stimuli are going to have some reaction to that stress. And, it acknowledges that these reactions could be temporary but they’re going to be there.

When you move into the Orange Zone, this is considered Injured and this acknowledges some sailors are going to be impacted in a way that decreases their mission effectiveness. And for most, in this Orange Zone, this is a temporary state that includes that some actions that both service member as well as leaders and caregivers can put into place to prevent them moving even further into the Red Zone.

The Red Zone is considered Illness. Acknowledging that a small number of people, probably around 15 to 25 percent, are going to develop some stress-related illness that is considered a diagnosable mental health condition that may require six to 12 month for the individual to be mission ready. And the metaphor that is used for this model is a sprained ankle. So, that when you have stress on a system, you can push it to a certain point. But, beyond that point, it need some form of intervention. The Marine Corps has incorporated this model by having in place many different layers of intervention across the range of stress continuum.

The primary tool for prevention in the Navy and Marine Corps is a set of early intervention procedures called Combat and Operational Stress First Aid (COSFA). This was first developed through collaboration with the Navy Marine Corps Defense Center of Excellence as well as the National Center for PTSD, built on a framework of Psychological First Aid that was developed by the National Center for PTSD and the National Child Traumatic Stress Network. And, the Combat Operational Stress Model includes some factors that caregivers, leaders, as well as service members can put into place for themselves or for each other that is meant to be preventative of longer term mental health issues.

So, the seven actions of Combat Operational Stress First Aid are:

Making sure that you’re constantly checking and reassessing how yourself and each other are doing. Coordinating, so that if you need additional care, you are always aware of what’s available. So if a person needs more than what’s available, you can refer them. Cover is trying to get a person to safety or helping them feel safe psychologically. Calming is a way to reduce physiological and emotional stress and arousal. Connecting is ensuring social support from both peers and family.
Competence is restoring a sense of self-efficacy and the feeling that they can handle what's happening. And finally, confidence is restoring a sense of both self-esteem as well as hope.

These are based on evidence-informed principles that the National Center has been aware of for some time and now we are tailoring this for the military environment.

The Marine Corps also has in place in their spectrum of services a very strong focus on leadership for military leaders to reduce the burden of stress on their members. I wanted to point this out in particular because as you can see service members coming out of the Army versus the Navy or Marine Corps, it may be that service members of the Marine Corps have a different viewpoint about how they were taken care of in service. Because the military leaders in the Marine Corps, in particular, because of their strong combat exposure, they are advised to function within this spectrum of Strengthen, Mitigate, Identify, Treat, and Reintegrate. Which basically translates into trying to train your people well, trying to make sure you're reducing the burden of stress as much as possible, trying to identify stress early on, and treat it first within the combat stress first aid model as well as mental health formal treatment. And finally, reintegrating the service member back into the mission if possible. So they're not wanting to treat and remove; they're wanting to treat and reintegrate. So, it's a nice model that they hope makes the service members feel that they're part of a team that supports them, and acknowledges that that they've been exposed to stress and tries to work with them rather than just removing them from the system.

So, as I said before all of the branches of the service include elements that are meant to build resilience as well as to intervene when service members are experiencing mental health problems. I want to focus on the difference between Army and Marine Corps just so you get a better sense of how these programs are operating. So, as I mentioned before, Army focuses on building resilience through the Battlemind program and the Marine Corps has the Combat Operational Stress Control which includes the Stress Continuum and the Combat and Operational Stress First Aid, as well as the core leader functions for building resilience.

The first line interventions in each of these branches include Battlemind debriefing, in the Battlemind spectrum of services for the Army. It also includes this concept of PIES which is Primacy, Immediacy, Expectancy, and Strengthen people to return to duty. The Combat and Operational Stress First Aid is the primary first line of intervention for Marine Corps and they also work with PIES, and then they have the strong leadership to intervene early on and try to reduce potential for long-term mental health intervention.

In each of these branches, their secondary interventions include mental health treatment within the service, as well as strong training for chaplains to deal with issues of combat exposure, conflict injury, where people have issues related to their values and moral standing, that type of thing. Both branches of service have family service centers that have counseling, couples counseling, training programs to teach life skills, that type of thing. Both branches of service refer out to TRICARE and also, Military OneSource is being used by all branches as an online resource that includes online interventions, email, referring people to different resources in their area, and education on this website.

I just want to briefly say that all service branches are very strongly focusing on evidence-based interventions for PTSD. So, when I spoke with representatives from Army as well as Air Force, Navy and Marines, they're all doing very large-scale trainings on cognitive processing therapy (CPT) as well as exposure-based interventions and trying to get this out to all professional care givers so that service members have the optimum opportunities to be treated within the service. This is very different from the way it used to be done. It used to be a medical board situation where if they were diagnosed with PTSD, they were removed. Now, the interventions include provision for six to 12 months depending on service and the situation—six to 12 months of in service treatment before they're considered for medical board.
And that depends a lot on circumstances, but that's important for you to know because as you're receiving service members they may have had already had some pretty substantial treatment intervention before they get to you.

Ok, so we've talked about military structure and terms; we've talked about stressors; and we've talked about some of the programs that DoD has put into place to build resilience and intervene within the service. Now, we're going to talk about how some of this has implications for VA clinicians working with individuals who report with PTSD.

In terms of working with clients with PTSD, we need to start with the issues around assessment. So, the first one is just basically trying to figure out what their exposure history was. And there are a number of different ways that you could ask about exposure history.

What we have found to be more effective than asking directly, “Were you exposed to trauma?” is to ask in a more indirect way, such as, “Did you have any particularly intense or difficult experiences that stick with you?” Or, you may find that it’s more helpful to ask in an even more indirect way, such as, “Were there any assignments or events that your fellow service members found really challenging or that stick with you now?” Now the reason for this is that you may find that if you ask the question directly, “Were you exposed to trauma?” some of what happens is that they don’t experience what happened to them as trauma or traumatic stress. They think of it as the normal course of their duties or difficult experiences. So you have already qualified by saying “trauma.” And if you ask in a more indirect way, you are less likely to stir up either denial or some sense of defensiveness.

In a similar way, when you’re working with military members and want to ask about military sexual trauma, we found that it’s better to ask rather than a general question about, “Have you had any sexual trauma or sexual assault?” to ask a very specific concrete behaviorally anchored question, such as, “While you were in the military, did you receive uninvited or unwanted sexual attention such as touching, cornering, pressure for sexual favors, or verbal remarks?” or “Did someone ever use force or the threat of force to have sexual contact with you against your will?” Now these sound like very long questions, but because people interpret sexual assault or sexual advances very differently, this kind of behaviorally anchored question tends to yield more detailed, accurate responses to your questions.

Next, in terms of assessment, when you’re working with either Veterans or Active Duty service members, it's always important to ask about their length in service as well as their deployment history because they're going to have different stressors across the course of their career and they're going to have different stressors depending on what types of deployments they had, what length of deployments that they had, and where their deployments were.

Another important fact to keep in mind is other adversities that they've experienced both in the past as well as in the present. We know from the literature on PTSD that ongoing adversities tend to be one of the strongest factors that is related to maintenance of PTSD. So, it's important to get a sense of both where they've been and also where they are now to look at their resources.

Education and treatment while in Active Duty is important, because that will frame the way they think about the reactions that they're having. So depending on how they were exposed to different concepts about trauma and PTSD as well as different treatments, it may have a big impact on the type of treatment you're able to engage them in. We've had people come in who had poor experiences with mental health treatment in the past and it makes them very resistant. We've had people come in with very positive experiences and because of that they're more open and willing to engage in long-term treatment.

Next, discharge type is important because it has an impact on their way of viewing the military, their way of viewing themselves, and has a very great impact on how they're going to engage with you. So, if they
feel good about their service, if they feel good about the way they were treated, and the way they were discharged—if you are dealing with a Veteran—they're more likely to engage in treatment and have a positive viewpoint of themselves as well as their experiences.

We know that particularly with military service members who have been discharged in a negative way, they tend to resist both the military as well as the VA system. So if you're sensing some resistance or hostility on the part of the service member or Veteran, this might be an area that you need to delve into and find out how they view the VA system as well as mental health treatment.

The longer a person has been in service the more likely it is difficult for them to adjust out of military into a civilian environment and that can have an impact on their recovery from PTSD as well. So knowing that there are stages, we've even looked at this in terms of acculturation stages, where people react to their new environment in a positive way and they react against it in a negative way—getting a sense of where they are in that process of coming out of the military can have a big impact on how they receive your viewpoint and how they view themselves in the process of recovery.

And finally, the area that I want to talk about as an implication for a VA clinician is when you're working with Active Duty members seeking care for VA, many VA clinicians don't know enough about this system and how this works—that you would be seeing an Active Duty member—so I want to point this out and then move into compensation and pension.

So for VA providers who are seeing Active Duty members, it may be important for you to know there are military transition units all over the country, for instance, West Point, Fort Drum, Boston. These are medical units for Active Duty who are injured or on Med hold for some reason and they also come from polytrauma treatment centers, so they could have a combination of TBI or some sort of physical injury in addition to some sort of stress injury. So while they're waiting to get better the military will, instead of medically boarding them out of the military—they want to give them a chance to get some help; see if they can work it out and reintegrate—or they also want them to have some assistance and support while they are being boarded out. So they're allowed to go close to home while they wait and they're supposed to call into their platoon sergeant every day, but in the meantime, they're eligible for VA care.

So it's important for you to know that as you treat them, they're considered medically on medical hold status and it may be that they go back to their original units, but it's important for you to know that their records are open to DOD while they're under your care. This is important because of the way that you write their records, for instance, about things like possible stress exposures or their reactions, is going to be open to the military seeing your records.

It's also important to know that while you're seeing them, there may be a pre-deployment/post-deployment situation where they're still recovering from a previous deployment and they're asked to go back out to another deployment. Some of the reactions that they present to you may be post traumatic stress reactions or they may be pre-deployment anxiety reactions. So that can be a challenge of working with service member in this phase because they had anticipatory anxiety and your job is to try to figure out A, how to tease that out and figure out what's PTSD and what's anticipation and B, trying to figure out how to implement some sort of program to help them with their catastrophic anxiety in advance of what they're going into. It can be a real challenge for VA clinicians.

Next, the military is often expressing to service members that even if they don't feel completely fit to go out, they have to go back out and be redeployed. So there sometimes are situations where the VA is looking towards you in one way or another, your records to determines whether a person is fit for duty and we would recommend that you talk with a social worker who's a Med hold case manager. They will be able to give you more information about your role and what role your chart notes are going to have on determining fitness for duty.
Finally, I want to move into compensation and pension because as you're working with newly separated or even long-term Veterans, you may be in a situation where you're going to be reporting in one way or another to the compensation and pension board. Now the VA is making an attempt to very much keep the benefit side of the House separate from the treatment side of the house so the VA providers are not supposed to do compensation and pension evaluations. But, there may be times when the compensation and pension board wants to see your case notes, in which case we would recommend that you contact a Veterans Service officer to find out what your role is supposed to be and what your obligation is to share those notes with a compensation and pension board. It could make a very big difference as to how you keep case notes and that type of thing. So these types of factors are important for you in working both on assessment and treatment side to determine how you can document what's happening as well as how you can work with a service member.

In conclusion, this module has been designed to help you better understand a number of factors related to military culture including military terms and demographics so you can know how to address service members properly and understand the background from which they've come; identify stressors in the military such as life threat, loss, ongoing wear and tear and inner conflict; to be more aware of programs offered by DoD for dealing with combat and operational stress both on the resilience building side as well as mental health treatment and intervention; and to recognize the implications for you as a VA clinician of working with individuals from a military background.

The fact that you've sought this course out shows that you care about your Active Duty and Veteran patients. Hopefully, this information will help you understand their background, ask the right questions, and know how to intervene with them in a way that's most effective for them.

If you need more resources, we have a link at the top right side of this page for more references and online information, and realize that it's part of the military culture that if you don't know something when you're working with somebody it's OK to say 'I don't know but I will find out.' It's OK to then go on and ask for further information from colleagues or military mentors or go online and find out more information or other resources.

Thank you so much for taking the time to view this course and we hope this course has been helpful in the services you provide for Veterans and service members.