

Support for Policy Changes for Therapy Related to Homefront Missions

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Background: As a result of recent policy change, National Guard and active-duty Reserve service members now have parity with combat veterans to obtain therapy for symptoms arising as a result of their activation for service on homefront missions.

Observations: Because the authority to treat soldiers serving on homefront missions is new, this article offers suggestions for service delivery to best meet the needs of this population.

Conclusions: Now that National Guard and Reserve component soldiers who have responded to national and local emergencies are eligible for therapy, we need to be prepared to provide these services. In addition to addressing systemic staffing concerns, therapists need to be aware of the unique challenges faced by those who have served on homefront missions.

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Recent natural disasters, civil disorder, and the COVID-19 pandemic response created an unprecedented demand for the US National Guard and Reserve components as well as active-duty personnel to serve on homefront missions critical to our nation. At times, those serving in these capacities are front and center to the most tragic events confronting our nation, and they frequently encounter tremendous suffering.

Recognizing the potential for these missions to create psychological sequela for those who serve on them, the authority for the Veterans Health Administration (VHA) vet centers to provide readjustment counseling services was broadened on December 30, 2021. Vet centers are community-based counseling centers that have traditionally served combat veterans, and broadening services reflects a major change in mission. Revised VHA Directive 1500(2) specifies that those who “served on active duty in response to a national emergency or major disaster declared by the President” or “served on active duty in the National Guard of a State under orders of the chief executive of that State in response to a disaster or civil disorder in such State” may now receive therapy at vet centers.^{1,2}

As a result of this recent policy change, National Guard and active-duty Reserve service members now have parity with combat veterans to obtain therapy for symptoms arising as a result of their activation for service on homefront missions. As they seek care, we need to be ready so that these service members can obtain the

best therapy services possible. Soldiers who served on homefront missions comprise a new cohort of service members now eligible for vet center therapy. Soldiers who served on homefront missions may present with issues that differ from those of combat veterans and veterans who have experienced military sexual trauma (MST), the populations treated by vet centers and other VHA mental health care clinics prior to this broadened authority. This article highlights some suggestions for service delivery to best meet the needs of this population.

DISCUSSION

Available evidence-based therapies to treat posttraumatic stress disorder (PTSD) are effective regardless of whether the trauma occurred in combat, on the homefront, or in a civilian setting. The vet centers and VHA mental health services already have staff trained to deliver these therapy modalities and, in this sense, are ready to provide trauma-focused therapy treatment to soldiers with PTSD who served on homefront missions.

The broadened authority for the vet centers to provide readjustment services is necessary, as it corrects for a critical gap in services, but the importance of ensuring adequate staffing to meet the expected increased demand for services cannot be underscored. According to clinical practice guidelines for the treatment of PTSD, developed by the US Department of Veterans Affairs (VA) and the US Department of Defense (DoD), the therapies with the strongest evidence-based backing are prolonged

exposure-based therapy (PE), cognitive processing therapy (CPT), and eye movement and desensitization reprocessing (EMDR).³ These therapy modalities, based on findings from clinical trials, are predicated on seeing a client for a sufficient number of sessions. Attendance at these sessions is recommended at least weekly to ensure adequate intensity of service delivery.⁴⁻⁷ According to the National Center for PTSD, PE typically involves 8 to 15 weekly or twice weekly sessions; CPT requires 8 to 14 or more weekly sessions, and EMDR is usually 4 to 12 weekly sessions.⁴⁻⁷

Ensuring adequate staffing is critical to offer these therapies at least weekly as the efficacies of these therapies are otherwise not proven if return session visits are stretched out over multiple weeks or months. The most recent clinical research has demonstrated that PTSD recovery can be expedited and there are lower patient dropout rates when sessions are massed or compressed so that multiple sessions are administered over 1 week.⁸⁻¹² Providing these therapies in a massed format has shown to be as effective as when these therapies are provided weekly.

As the authority to treat soldiers serving on homefront missions is new, epidemiologic data do not yet exist to estimate the proportion of this population who will need treatment or present with PTSD, depression, anxiety, a substance use disorder, and/or comorbid conditions. Those with PTSD can benefit from PTSD evidence-based therapies already available for treatment. Others may benefit from treatments that are proven effective for their mental health diagnoses.

Therapists with experience primarily treating patients with PTSD related to combat or MST will need to be sensitive to the unique experiences of the National Guard and Reserve service members. For example, this component of soldiers served on COVID-19–related missions that provided food service support to nursing homes residents who were locked down from family members. As a result, they developed bonds with residents who later died. This may have been the first time that these soldiers witnessed death. If such a soldier is assessed and does not have

PTSD but is nonetheless distressed, then the soldier may need alternate therapies, such as grief counseling. This need may be more pronounced for those soldiers who lost loved ones to COVID-19 while they served on these missions.

New Jersey Army National Guard soldiers provided food service support at the Woodland Behavioral and Nursing Center in Andover, New Jersey. These soldiers witnessed the unfortunate conditions in this facility, which included stacked bodies in a makeshift morgue during the height of the pandemic; however, they did not have the ability to make changes. The facility is under investigation for abuse and neglect of its residents.¹³

New Jersey National Guard soldiers supporting that facility and similar ones may have experienced moral injury, defined as “...perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations.”¹⁴ Importantly, when these soldiers present for therapy and express moral injury, their therapists need to be open to spiritual discourse. However, vet centers do not have chaplains on staff, so therapists must refer patients to chaplaincy services.

Among therapists with existing cultural competency for treating members of the military, some nuances exist for National Guard and Reserve service members. National Guard and Reserve component personnel already may feel that their problems are less important than those experienced by active-duty service members. Now that these soldiers have the eligibility to receive therapy, therapists may have to make extra efforts to both reassure this population that they are welcomed and to validate their need for services.

Special outreach efforts to those who served on historical National Guard and active-duty Reserve missions are a way to show good faith in serving these soldiers because they may have untreated PTSD or other undiagnosed mental health disorders related to earlier deployments, such as hurricane recovery missions. A study of disaster survivors found that the prevalence rate of severe and very severe psychological impact after a natural disaster was about 34%.¹⁵ Another epidemiologic study

found that the prevalence rate of PTSD was 10% to 20% among disaster rescue workers.¹⁶ Specific data about the psychological problems of National Guard and Reserve components serving in disaster recovery are unavailable but is an area for future research.

Therapists who have treated active-duty service members and veterans who worked in mortuary services in a combat zone are used to hearing graphic details of horrifying scenes, but homefront experiences are different. Soldiers on homefront mortuary-based missions frequently reported being unable to forget the faces or the smell of dead bodies as they were stacked up and overwhelming the systems. Experienced vet center therapists should be prepared for the challenges in treating this new cohort of patients.

CONCLUSIONS

Now that National Guard and Reserve component soldiers who have responded to national and local emergencies are eligible for therapy, we need to be prepared to provide these services. In addition to addressing systemic staffing concerns, therapists need to be aware of the unique challenges faced by those who have served on homefront missions. These homefront missions have the potential to hit home for therapists.

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Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the U.S. Government, or any of its agencies.

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