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Symptoms and Treatment for Military Veterans Suffering from Post-Traumatic Stress Disorder

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Abstract:
This article will focus on treatments for veterans with Post-Traumatic Stress Disorder (PTSD). Many veterans returning home are haunted by experiences that happened while oversees and are not receiving the help that they need. PTSD due to combat exposure in the military can cause veterans to feel afraid, confused, and angry. This article discusses how to assess veterans for PTSD, develop treatment plans and goals, intervention methods, and eventually; terminating the therapeutic relationship. Also, discussed are strategies on how to evaluate PTSD patients.

Keywords: *PTSD, veterans, therapy, assessments, treatment, intervention, termination, combat, war, military*

1. Introduction

The functional roles of social work have greatly expanded in treating military service-members, veterans, and their families since the Invasion of Kuwait in 1990 (Operation Desert Storm). The Selective Training and Service Act was passed in 1940, which provided for a military draft to staff the Armed Forces of the United States during both war and peacetime. This system was utilized from 1940 until January of 1973. With the unpopular Vietnam War winding down, the Selective Service announced there would be no further military draft calls. Since then, the U.S. military has operated with an all-volunteer force. Unfortunately, the downside with a reduced, finite military conscription is that multiple deployments have become the rule and returning service members must cope with unrivalled biopsychosocial issues. Biologically, there is the issue of Traumatic Brain Injury (TBI) stemming from increased use of roadside improvised explosive devices (IED). Hostilities in the Mid-East lack a clear frontline that greatly increases risk for both combat and noncombat personnel. The ongoing threat of danger provides the psychological factor to a growing frequency of PTSD among returning service members and veterans. In a war where the enemy is not a foreign country, but rather a subset of the population, U.S. military personnel are left in a never-ending state of caution and vigilance. It is unsettling to realize that any civilian could be an enemy insurgent with the likelihood of an ambush occurring at any time or place. Enemy fighters dressed in regular civilian clothing have frequently used women and children as cover to gain an advantage of attack. These conditions perpetuate a constant state of hyper-arousal. While this is an adaptive means of self-preservation during dangerous combat assignments, our mental make-up has a difficult time turning it off even when the component of danger has been removed. The result is the probability of adverse symptoms of PTSD after returning home. Often, combat related stressors are further exacerbated with intense guilt and feelings of culpability for friends lost in battle.

Therefore, treating service members for PTSD related to combat exposure could be even more challenging than treating most common forms of PTSD. The anger and aggression associated with combat trauma tends to be substantially more formidable than PTSD experienced by the civilian population. Furthermore, combat related PTSD has a comorbidity with several other conditions that is common for service members returning from overseas. Because of these unique factors, PTSD among service members will typically be more complex and longer lasting, which is likely to require prolonged treatment regimens. As such, exposure therapy treatment options need to be more flexible than for civilian forms of PTSD and will commonly need to be merged with interventions that target a comorbid disorder such as suicidal ideation and substance abuse.

Little is known at this time regarding the effectiveness of PTSD treatment in the military. There is a stigma associated with any outward display of weakness, as well as possible negative consequences to their military career that prevents active duty members from being receptive to treatment options. It is crucial for commands to notify subordinates regarding availability of health services being offered. Additionally, there should never be fear of reprisal. As a military veteran, I've seen first-hand the effects that difficult deployments and separation from family can have. While serving on active duty, I do not recall preventative health services ever being offered. This is a case where top military officials must 'walk the walk' and commit to proactive wellness programs. Command officers and Non-Commissioned Officers must remain vigilant for veiled warnings of PTSD. For service members receiving assistance, there should be a support group to contact with a list of actions they agree to take.

Within social work, the treatment process is made up of several phases. Although they are broken down into different categories, they tend to overlap during treatment. Each phase has its own particular tasks that are emphasized. Initially, we review issues in referral where we examine how the client came into the system. In the next phase called *Engagement,* the therapist builds a rapport with the

client and begins to form the therapeutic relationship. This is realized as the therapist gathers information about the client.The *Assessment* phase runs concurrently with the previous phase. During the assessment, the therapist evaluates the client, develops diagnostic impressions, and cultivates a working hypothesis about the client with respect to their situation. From here, the therapist can develop *treatment plans* and *goals* to help treat the client. In the next phase, *Methods of Intervention*, the therapist implements the various interventions that have been identified to assist the client with their problems. Recognizing these interventions includes an evidence-based search to identify best practices for the particular type of issue associated to the particular type of client.*Termination* consists of the ending the therapeutic relationship process. The therapist and client summarize and evaluate the work they've done together and discuss any issues that can be addressed in the future (Leahy, 2011).

2. Issues in Referral

Upon completion of my term of enlistment in the U.S. Navy, I began working for a service organization as a Veteran Service Officer. A primary responsibility of my function was in processing disability compensation claims through the Veteran Affairs (VA). Currently, I am working at an inpatient psychiatric facility, where I am the only veteran therapist. In this role, I typically receive all veterans' cases. In both of my functions, I have observed the many hardships veterans dealing with PTSD must endure. My experience conveys that veterans avoid reporting issues while on active duty for fear of appearing weak or retaliation. It is noteworthy that service members and veterans with PTSD typically have been given an ultimatum or hit rock bottom before considering getting help. Often, friends and family are helpless to effect change and can have a difficult time watching, or in many cases living with this situation. Hitting rock bottom differs from person to person, but some examples of self-destructive behaviors are loss of a job, separation or divorce, troubles with law enforcement, a failed suicide attempt or long-lasting suicidal ideation, domestic violence, etc. Veterans suffering from PTSD tend to be in denial and can find temporary respite with substance abuse. Another common defense mechanism is to blame everybody else for their issues before realizing that they need help. In the military you are taught a number of values, some that are good to keep forever and others that are more appropriate for certain situations. Military personnel are trained in a tough environment and are encouraged to be strong and overcome all obstacles. It is exactly this macho idealism that leads service-members to believe that a request for help is a demonstration of weakness. Sometimes the personal losses are very high due to this ingrained belief. Sometimes vets will go at it alone for years with this struggle before eventually seeking the help they need.

3. Methods of Engagement

In the early stages of therapy, key elements are to establish rapport, engage the client, and gather information. Information gathering is used to develop rapport. Building rapport with a client is in the service of the therapeutic alliance. The therapeutic alliance is an agreement to work on the client's problems and goals together. There is a shared responsibility between the social worker and the client for the best possible outcome. The therapeutic alliance is formed by the patient's reasonable ego. That is, the relatively rational, non-neurotic relationship between the patient and therapist. It's the part that is not transference (Williams, 2002).

Studies show that the key ingredient across all types of therapy, no matter what the theoretical orientation, is the therapeutic relationship. It is analogous to the holding environment described by D.W. Winicott. The nature of the holding environment has six characteristics. *Dependability* is when the social worker makes a commitment to the client to be available when they say they are going to be, thus allowing the client to be able to count on them. *Reliability* is when the social worker is present; although this could be as simple as listening as the client describes feelings, wants and desires. A relative similarity would be that of a child playing happily by himself, with the reassurance that his mother is nearby. *Support* involves understanding, empathetic warmth, and fostering from the social worker. Next is the concept of a *container*, which implies that the social worker can contain the client's negative and unacceptable affects, such as rage and dependency from PTSD symptoms. Perhaps the key ingredient in the holding environment is the *good enough therapist*. A good enough therapist need not be perfect. If frustrations occur in manageable doses, the client does not overwhelm and the therapist is able to maintain objectivity. Last, is the *provision of a more structured holding environment*. This could be a VA Medical Center, a day treatment program, or simply more frequent appointments. Together these six components form a secure holding environment from which the client can begin his exploration (Williams, 2002).

Forming a rapport with a veteran that has PTSD can prove difficult because of several factors. The most significant is that many veterans do not want treatment and an antagonistic attitude makes them difficult to deal with during therapy. Many veterans that show symptoms of PTSD never get help or leave treatment early. The U.S. Army has estimated that fewer than half of veterans suffering from PTSD actually receive the help that they need. Of veterans that actually begin treatment programs, about half of them stop going after the first few sessions. One of the key reasons for avoidance of treatment is from a general lack of trust veterans have towards mental health professionals. Many also believe that their psychological problems will work themselves out through the natural course of time and that treatment should only be used as a last resort. The Armed Forces and veteran programs could help greatly by doing a better job promoting these services. Stronger efforts should be made to keep service-members and veterans already receiving these services to continue with their program by matching them with better treatment models and helping them want to continue treatment through a strong rapport (Monson, 2006).

While discussing traumatic events, the client can become quite uncomfortable. Clients from different cultural backgrounds can present additional challenges. There really is no 'one size fits all approach' to getting the client to open up about stressful issues. With differences in cultural norms, there are differing perspectives regarding mental health issues that can make it difficult to obtain accurate information. There needs to be awareness for the social worker that what is wrong or incorrect in one person's culture may not necessarily be the same for another individual. Even being raised in the same country does not assure a similar environment and set of values. Social workers must take care to provide clear explanations and remain sensitive to diversity. Make sure they

understand where you are coming from and maintain an open dialogue. Invite the client to interject with any questions or issues (Williams, 2002).

4. Assessment Framework

When assessing a client you are examining their ego-functions, socio-emotional functioning, and environmental context. Embedded in the assessment is what's referred to as a mental status exam. *Ego functions* are often described as the essential means by which an individual adapts to the external world. When observing ego functions, we are assessing them on their reality. As the therapist, it is important to consider and evaluate to what extent the client can distinguish between inner and outer stimuli and how accurate that perception is. Is there evidence of hallucinations and/or delusions? An example of a client with poor reality testing could be somebody hearing voices emanating from the walls. Reality testing also includes accuracy orientation to time, place, person, and situation. If this is so, the patient can be described as oriented times four (Hepworth, 2012). Once again, be cognizant of cultural differences that can influence reality testing. Therefore, a good question to ask the client in order to make this determination is, "Does your family feel the same way?" "Why?" "Why not?"

Coherence is a second ego function and can be described as the ability to organize mental processes into a coherent form. It has also been referred to as the synthetic integrative function, as it merges various disparate aspects of the personality into a unified structure that acts upon the external world (Woods, 2000).

Also consider the clients impulse control. Do they behave impulsively, moving from stimulus to response without thinking? Do they seek immediate gratification or can they postpone satisfaction?

Judgment is the fourth ego function. Is there an awareness or expectation of consequences for actions and does their behavior reflect this awareness? In our role as the therapist, it is essential to remember that everybody exhibits poor judgment at times. However, we must dig deeper to ascertain the frequency and degree for occurrences of poor judgment (Hepworth, 2012).

The next consideration is the client's coping style and defense mechanisms. The therapist will determine how the client typically addresses problem resolution. Do they utilize adaptive coping strategies, such as looking for information on an issue or do they incorporate primarily maladaptive coping, such as self-medication which serve to distort reality? Does the client rely on defense mechanisms, such as denial or projection as a means of dealing with anxiety? It is an important consideration to understand if the clients' thinking is cognitively flexible or rigid. For instance, we would contemplate if the client filters their information through a particular screen, such as, 'people are out to get me' or if they allow new information to influence them (Hepworth, 2012).

Insight is the ability to comprehend cause and effect, such as how behavior and personality traits have contributed to their difficulties. It is often used to denote how or where a client is about his intra-psychic processes and where they come from (Woods, 2000). For example, does the client recognize that their nightmares and flashbacks are the result of their war experiences?

A client's self-concept and self-image are the final ego functions reviewed during the assessment. These terms are often used interchangeably as they reference how the client perceives themselves in terms of various dimensions; such as good or bad, kind or insensitive, smart or dumb, weak or strong. Self-esteem and self-confidence are dimensions of this ego function (Woods, 2000).

In addition to assessing the client's ego functions, the clinician will be collecting other information included in the Mental Status Exam (MSE). The MSE first evaluates the client's appearance and attitude (Woods, 2000). Notice how the client is dressed and whether they are appropriately groomed. At the initial meeting, how does the client approach the interviewer? Are they cooperative, guarded, hostile, etc.? Also, what is the client's temperament? Does he tend to lose concentration or become inattentive? Likewise, make note of the client's speech and language patterns. Does the client use loose associations, flight of ideas, or tangential speech? Are there gaps and delays while speaking?

Diagnostic criteria for PTSD consist of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition (DSM-5). Per the DSM-5, below is the current criterion as of 2015.

4.1. Criterion A: Stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

4.2. Criterion B: Intrusion Symptoms

The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).

3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

4.3. Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

4.4. Criterion D: Negative Alterations in Cognitions and Mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

4.5. Criterion E: Alterations in Arousal and Reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

4.6. Criterion F: Duration

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

4.7. Criterion G: Functional Significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

4.8. Criterion H: Exclusion

Disturbance is not due to medication, substance use, or other illness.
(DSM-5)

Before diagnosing a patient with PTSD, exposure to the traumatic experience that involved actual or perceived threat of death or serious injury should be confirmed. Notice how the veteran describes any intense fear, helplessness, or horror that accompanied the traumatic event. The therapist should note any persistent or disturbing themes, as well as images and perceptions relating to the traumatic event. While it is common for the veteran to intentionally avoid thoughts, feelings, discussions, activities, places, people, or objects that could remind him of the stressful situation, it is important for the therapist to discover if they relive the event through flashbacks or are experiencing frequent nightmares. Sometimes people suffering from PTSD will have the inability to recall numerous important aspects of the traumatic event. Veterans may also find it difficult to love people for a fear of losing them and can easily become agitated and angry. They may also spend a large portion of their day in a state of hyper-vigilance and have an exaggerated startle response. These are some of the details that can provide additional insight during the assessment for PTSD (Moore, 2009).

5. Treatment Plan and Treatment Goals

After a thorough assessment, the therapist should then begin to gather data. The therapist will monitor outcomes and make appropriate adjustments to the intervention based on this data. However, another aspect to evidence-based practice involves the focus on specific interventions. For example, if a veteran comes in displaying several classic symptoms of PTSD (e.g., flashbacks, fighting, loss of employment, substance abuse, etc.), there are a number of successful treatment options that have been developed and validated by clinicians (Hepworth, 2012).

The primary objective is for the client to return to the level of psychological functioning that they displayed prior to being exposed to the traumatic event. Preferably, the client should no longer feel the need to avoid people, places, activities, and objects that are reminders of the traumatic event. A secondary goal when treating veterans with post-traumatic stress is to eliminate or minimize the negative effects on their family, occupational, and social functioning. The client will be encouraged to think or discuss openly

regarding the traumatic event that they experienced to others without experiencing any distress. Wellness includes reclaiming their "warrior" mentality and the confidence as a proud veteran or service-member.

6. Issues in the Worker-Client Relationship and Contracting Issues

When treating clients, there are potential barriers to implementation of the intervention plan. The treatment goals outlined to this point presume clients who are willing and motivated to seek counseling. However, frequently it is necessary to care for clients who are not motivated for treatment. Examples of involuntary clientele include cases that were mandated by court, individuals that are hospitalized or mentally ill, a reluctant spouse, or a problem drinker that was referred by his employer.

In such cases, it is paramount to outline objectives clearly in terms the client can definitely relate to. The goals should be presented as a mission with the therapist taking personal responsibility to represent the organization to the best of their ability. With that, the goal is to assist the client in every way feasible. However, process differences exist. Contracting and setting goals with involuntary clients are based on a model that is unlike the therapeutic model that we would regularly follow. It is often referred to as the Social Conflict Model and is based on conflict rather than cooperation. Commitment to the therapeutic process may be different because the goals of the involuntary client can differ from those of the organization.

There are various contracting strategies that have been found to work well with these types of involuntary clients. *Agreeable Mandate* strategy strives to find a common ground. The aim is to find a goal that the client can agree to. For example, the client agrees to a modified treatment program to resume normal employee status with his company (who referred him for treatment via Employee Assistance). Another widely used approach is the *Quid Pro Quo* strategy (also known as the "Let's make a deal strategy"). An example would be for the social worker to ask the adolescent client, "If I can get your wife to stop staying at her mother's, would you stop breaking things at your house?" The *Get Rid of the Mandate* strategy revolves around take the steps necessary to get the agency off the client's back. For example, the father that just wants his children returned and Child Protective Services (CPS) out of his life. *Self-Defeating Consequences* strategy is when the client is reminded that not working with the social worker defeats his purpose of having as much control over his destiny as possible (Moore, 2009). Consider, for example, "If you decide not to participate in counseling, you are choosing to allow me to have total control over what happens to you. On the other hand, if you do work with me, you'll have input into the decisions made about your family, which will directly impact you." In such cases, it is beneficial to give as much control as possible to clients even for simple matters like allowing them to set up their scheduled appointments.

Dealing with clients that are adverse to treatment could cause the therapist to avoid confrontation with the client because they are afraid of what the resistance means and whether they can handle the feelings that may come up. The client might reveal that he does not like the therapist and wants to end his treatment. The emotional confrontation can in turn create a stressful environment for the therapist. It is important to note however, that when resistance is communicated, the client is actually less likely to leave treatment. By venting their negative feelings, it is no longer necessary to act them out.

Transference is present in all relationships, and can be both positive and negative. It is how the client communicates. Positive transference makes therapy possible and is needed to build the relationship between the therapist and client. Positive transference is important, such as when a client is entertaining or cracks jokes all the time. While this is enjoyable, the underlying motivation may be the belief or transference from early childhood that this is the way to engage someone in authority and divert the attention away from painful events.

Counter transference includes all the feelings the therapist displays towards the client. Some kinds of counter transference can be helpful in understanding the client. These two types of counter transference are neurotic and non-neurotic. Neurotic counter transference is the counterpart to transference; the Social Worker's unrealistic attitudes/feelings projected onto the client. Non-neurotic counter transference is based on the therapist's identification with the client and how he/she is able to identify and relate.

7. Methods of Intervention

Most of the treatments options for veterans experiencing symptoms of PTSD fall under the umbrella of Cognitive Behavioral Therapy (CBT). CBT focus is initially on the thoughts and behaviors associated with the trauma, and then how best to change those thoughts and behaviors. One issue many therapists fall into is that they become too fixated on the cognitive and behavioral facets and don't realize that there is also an emotional component to CBT. Wellness for the client is more than thinking differently; they also need to feel differently and appreciate how those thoughts and behaviors are linked to their emotional state.

There is some controversy on how a group of researchers can come up with an intervention that is strong enough to work for everybody. The reality is that these interventions do not work for everybody. Another point is that most interventions are not manualized. Most of the people that apply these methods are not researchers. They are creative, spontaneous clinicians who find these intervention techniques very useful to their practice when carefully applied (Hepworth, 2012).

Cognitive-processing therapy (CPT) is a problem-focused psychotherapy intervention that is an adaption of the evidence-based therapy (EBT) known as Cognitive Behavioral Therapy (CBT). CPT was originally developed for rape victims, but has been effectively used for a wide variety of trauma responses. Evidence has shown that it is a valuable intervention technique for a variety of conditions including treatment for PTSD. As CPT continues to grow, it has also been determined to be effective for other psychiatric disorders such as depression, panic disorders, generalized anxiety disorders, and obsessive compulsive disorder (Department of Health). The philosophy of CPT theorizes that PTSD is a "non-recoverable" disorder where flawed views regarding the causes and consequences of client's traumatic events produce powerful negative feelings that can prevent accurate processing of the traumatic experience and the emotions that originated from the past event. People suffering from PTSD go through a variety of emotions that include sadness, anger, horror, fear, guilt, and shame. Veterans often delay recovery from traumatic events by avoiding

any coping strategies. Because of this, the veterans' opportunities to process the traumatic events are very limited. Trauma-specific cognitive techniques are incorporated within CPT in order to help people that are suffering from PTSD to accurately assess these delays in their progress and help them to move ahead towards recovery (Wiliams, 2002).

CPT can be integrated into the biopsychosocial assessment and should be considered for use in certain situations. Examples of situations where it would be appropriate to use CPT for a client exposed to a traumatic event would be when the client displays an uncooperative mindset, minimal improvement has been made with medications, or when the client displays other significant psychosocial problems such as work related issues, negative behaviors (substance abuse, self-harm), or any other concern that cannot be resolved with medication alone (Williams, 2002).

There are four components to CPT. The first is educational, where the client receives an overview regarding the dynamics of PTSD. In CPT, clients are also taught how to become more aware of their thoughts. Quite often people have thoughts, but are not necessarily consciously aware of them. For example, it could be very helpful to have the client write out exactly what happened and examine their thoughts and perceptions about the events. Next, the client is taught to challenge those thoughts and feelings, with the most important lesson to become a bit more comfortable with new ways of thinking and feeling. Since many PTSD clients had found comfort in avoidance; it is important for them to process and change from these distorted beliefs and non-helpful behaviors in order to be able to change what they are doing. It is a gradual process to begin feeling better with a healthier lifestyle and thinking and feeling very differently.

Another type of therapy that can be effective is Prolonged Exposure Therapy (PET). Many researchers have linked PET under the Cognitive Behavioral umbrella, but it has also been described as informational and emotional processing theory and is based on classical conditioning. There are the unconditioned stimuli and the unconditioned response. An example of this would be if there was an explosion and you become startled and afraid, that is an unconditioned stimuli and an unconditioned response. Anybody who had almost been blown up would have experienced intense fear. What happens with PTSD is that we start to pair that feeling of fear with neutral stimuli (Foa, 2011). Here's an example that played out many times in Iraq. A convoy is moving down the road and as it passes by a seemingly broken down car on the side of the road, there is a sudden tremendous explosion detonated remotely. While the soldiers have adapted to some extent to the horrible conditions of war, later when the soldier returns home, he may react negatively to a neutral stimuli such as a broken down car on the side of the road. Now, when this individual with PTSD sees a broken down car, they can have an emotional (unconditioned) response that was previously related to that bomb that now becomes paired and is a conditioned response. Because of this, the goal of PET is to decouple that response so that when this client sees the car broken down on the side of the road, it is no longer associated with the war, but is simply a car.

Similar to CPT, PET has four components. The first part is to educate clients on the structure of PTSD. Then, there is a breath training and relaxation technique to help lower the anxiety levels of the client. After that they will do real-world practice where they will list out subjective units of distress. Using our earlier example, at some point the client who gets stressed out seeing beat up cars might consider a tour of a junk yard where they will see all kinds of beat up cars with the intent of changing that now conditioned stimuli back into an unconditioned stimulus. Another exercise is imaginal exposure where the client imagines the traumatic event exactly as it happened, reduce the association of that beat up car that exploded near the convoy and only see it for what it is, a beat up car (Riggs, 2006).

The issue of cultural congruence and relevance of an evidence-based intervention is immense. A considerable amount of scientific data based on evidence-based interventions hasn't assessed the success of these interventions for specific ethnic groups. However, there is the ongoing accumulation of data regarding application of specific therapeutic interventions with specific ethnic groups. It is incumbent for the therapist to understand those differences and reference those finding when dealing with a particular ethnic or racial background or gender. In essence, this shared information could be useful for development of best practices. If a client wants an intervention and there is no evidence base, a therapist may be willing to try it if that is their preference. However, many therapists would prefer an arrangement with the client where they could both assess how well the treatment is working. A therapist needs to be open to the fact that a client can have a good sense regarding intervention options and in many cases, it could be worth a try.

8. Termination

All things must come to an end. There can be a real loss in the termination phase, as well as a metaphorical one. This is true for both client and therapist. As with each phase of treatment, the termination phase has specific emphases and tasks to be achieved. It is important to understand that the termination phase is not simply the end of treatment or intervention.

There are six tasks in the termination phase. First, you need to deal with the client's feelings about termination. Then, it is important to review the gains made in treatment and progress that the client has made. This review serves as a reminder of new skills learned and helps to increase self-esteem by highlighting the progress made. After that, it is important to emphasize the client's strengths. It is important for all clients, but particularly veterans with PTSD, to anticipate future problem areas and times where they might become vulnerable. If appropriate, we would like the client to return for a "booster shot," if and when they feel it is necessary. It is also useful to remind the client of the organization's availability and other possible sources of support. Finally, we will evaluate the effectiveness of the treatment (Roe, 2011).

There are two common times for termination. *Forced termination* is untimely and unplanned. Some clients might terminate treatment prematurely or the worker's life could interfere with the completion of treatment. On the other hand, *voluntary terminations* are a timely, planned one and typically have successful outcomes. Where there can be joy and satisfaction with the termination of services, there could also be sadness with the client/therapist relationship coming to an end and the cessation of the support system the client was receiving (de Bosset, 1986).

9. Evaluation Strategy

When the end of therapy is nearing, it is important to evaluate the client in a manner similar to the original assessment. The termination phase can reactivate old losses and conflicts. Therefore, it is an ideal opportunity to work through any issues from the past that are still unresolved. During the Termination Phase, symptoms can reappear or new ones may show up. There are a few issues surrounding these symptoms. The first has to do with the meaning of the return of the symptoms. The client might be feeling, "How can you leave me now. I'm still in distress." Others may express anger with the return of symptoms and state angrily that you didn't help them at all. Understanding why symptoms are occurring is essential to termination. The second issue of whether or not to terminate when symptoms reappear is an important issue that the therapist must address. The therapist must assess what is really happening. If the client is acting out the dread of separation, then the therapist should help the client work through those fears. However, if the client truly does require assistance at this time, then additional sessions are warranted with either you or your replacement. Termination should be considered when the client's goals have been met or when the client is receiving diminishing returns from the therapy (Roe, 2011).

10. Follow-Up

Follow-up sessions are sometimes referred to as "booster-shots." These should be planned in advance with the client so there is no perception of an imposition. Some people do not want the follow-up session because, although therapeutically vindicated, they may not want a reminder of that difficult time in their life (Roe, 2011). Whether this avoidance would be considered as a defense or a coping mechanism should depend on how well they are functioning.

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