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Mental health impact of the Iraq and Afghanistan conflicts: A review of US research, service provision, and programmatic responses

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Abstract

Although documentation that war inflicts psychological casualties dates back to the American Civil War and earlier, most research began after the Vietnam conflict, when studies focused on post-traumatic stress disorder (PTSD). With ongoing conflicts in Iraq and Afghanistan, there has been significant research to illuminate the epidemiology of war-related psychological casualties. Significant findings include an appreciation for the role combat plays in the development of mental disorders, including PTSD and traumatic brain injury (TBI). Recent research has endeavoured to understand and improve psychological resilience to temper potentially adverse mental health effects of military service in the theatre of combat operations. Over 2 million US service members have now deployed and returned over 3 million times to the Iraq and Afghanistan conflicts. Mental health providers in the Departments of Defense and Veterans Affairs healthcare systems have consequently observed steep increases in mental health service use among these personnel. The Departments have responded aggressively to bolster staffing levels, increase capacity, improve available services, and anticipate future needs. Scientists and clinicians continue efforts to understand the determinants, prevention, recognition, and treatment of combat-related mental disorders.

Introduction

The first decade of the new millennium has yielded prolonged US combat operations in two major theatres, stretching the force and challenging public resolve. This period has also witnessed significant advances in military operational medicine brought forth by the necessity to identify and care for a growing number of service personnel manifesting mental health consequences. Focused efforts to reduce stigma, eliminate barriers to care, and increase viable options for assistance and treatment have led to increased resource use among those faced with war-related mental health issues. The medical and research community are still learning the extent that these efforts are mitigating the short and long-term mental health impacts of these conflicts. As we learn, we continue to examine and adjust the continuum of mental health research and assistance for US military service members, from screening, symptom assessment, and resilience training

before and after combat deployment to post-deployment clinical prevention, primary care recognition and early intervention, specialized treatment programmes, and disability compensation. This report presents our perspective.

Past psychological burden of war

On the evening of 11 November 2010, Veterans Day in the USA, the American cable television channel HBO aired a documentary titled 'Wartorn: 1861–2010'. This documentary chronicled the psychological impact of war from the American Civil War (1861–1865) through to the current wars in Iraq and Afghanistan. The overarching public health message in this powerful film was that post-war mental health and readjustment problems have been prevalent in the aftermath of wars throughout history and are evident today among surviving veterans. This documentary was consistent

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with findings from epidemiological studies of the burden of war-related readjustment problems among veterans of earlier and current wars.

Scientific interest in post-war clinical syndromes, such as post-traumatic stress disorder (PTSD) resulted largely from the post-war readjustment problems of Vietnam War veterans (Cozza, 2005). The National Vietnam Veterans Readjustment Study (NVVRS) (Kulka *et al.*, 1990) estimated the lifetime prevalence of PTSD for men was 30.9% and 26.9% for women, and the current prevalence of PTSD was 15.2% for men and 8.1% for women (Schlenger *et al.*, 1992). Later analyses of the same data using updated DSM-IV case criteria requiring significant impairment in functioning along with characteristic symptoms produced adjusted PTSD prevalence estimates of 9.1% for current PTSD, and 18.7% for lifetime PTSD (Dohrenwend *et al.*, 2006). Similarly, a large population-based sample of Gulf War veterans found that the prevalence of current PTSD was 12.1% in this cohort, with an adjusted current PTSD prevalence estimate of 10.1% (Kang *et al.*, 2003). Ten years later, the adjusted prevalence was 15.2% versus only 4.6% among non-deployed Gulf War era veterans (Kang *et al.*, 2009). Prevalence rates for PTSD after peacekeeping operations have been generally lower, with only 1% of Bosnia peacekeepers reporting symptoms of PTSD to 8% for those who deployed to Somalia (Maguen *et al.*, 2006).

The present psychological burden of war

The scientific exploration of mental disorders among Vietnam and Gulf War veterans established the foundation for what would lead to a substantially larger investment of resources to investigate the mental health of US service members who deployed to the Iraq and Afghanistan conflicts. In contrast to previous published studies of Vietnam-era and Gulf War-era veterans that were conducted a number of years after the cessation of conflict, all studies conducted among Iraq and Afghanistan deployers have been conducted while operations remain ongoing. Benefits derived from this approach are the potential to reduce biased recall of combat and related exposures and to use study results to design clinical and programme responses, and to influence policy decisions intended to improve and protect the health of the force.

Posttraumatic stress disorder

In an anonymous, serial cross-sectional survey study, Hoge *et al.* found PTSD prevalences for US combat troops returning from Iraq and Afghanistan to be 18% and 12%, respectively, compared to 9% before deployment (Hoge *et al.*, 2004). In a clinical sample

of US service members, 19% presenting to a mental health clinic in Kuwait reported PTSD-related symptoms (Felker *et al.*, 2008). Since 2001, the Department of Veterans Affairs (VA) has also experienced an increase in Iraq and Afghanistan veterans seeking care and diagnosed with mental disorders. Seal *et al.* determined longitudinal trends and risk factors for mental health diagnoses among a select sample of first-time users of VA services after the start of the Iraq/Afghanistan conflicts and estimated 21.8% received a provider diagnosis of PTSD (Seal *et al.*, 2009).

In recent years, significant gains have been made in understanding the relations between deployment and PTSD. Using anonymous samples and pre- and post-deployment questionnaires, Hoge *et al.* were among the first to document a positive association between exposure to combat and PTSD in US Army and Marine Corps personnel who served in Iraq and Afghanistan (Hoge *et al.*, 2004). This finding was supported by Smith *et al.* who used prospective Millennium Cohort data and found that US service members who deployed and reported combat exposures were at greater adjusted odds for PTSD than US service members who deployed without combat exposure, or were non-deployed (Smith *et al.*, 2008a). Maguen and colleagues found that 40% of conflict veterans reported killing in combat on post-deployment mental health assessment, and that killing in combat was significantly associated with PTSD, alcohol abuse, anger, as well as relationship problems even after controlling for other combat exposures (Maguen *et al.*, 2010a).

Traumatic brain injury

Current conflicts in Iraq and Afghanistan are somewhat unique because hostile forces employ more improvised explosive devices against US forces than previously experienced. With improved armoured protection, and advances in battlefield medicine and surgery, a greater proportion of service members are surviving significant injuries. Many of these survivors now face a life of health challenges related to traumatic or surgical amputation, traumatic brain injury (TBI), optical injury, and polytraumatic issues, all of which place them at risk for subsequent mental health conditions. Results from the US Army TBI Task Force reported estimates of 10% to 20% of soldiers with a combat-related injury also had a TBI (US Army, 2008), while internal Defense and Veterans Brain Injury Center data report that about 33% of those service members who required specialist care at Walter Reed Army Medical Center for combat-related injuries also had a TBI (French, 2009). For purposes of comparison, approximately 12–14% of Vietnam veterans (Okie, 2005; Schwab *et al.*, 2003) and 20% of 1991 Gulf War veterans (Carey, 1996; Leedham *et al.*, 1993) who survived their wounds had head

injuries. Two studies of Iraq veterans reported seemingly similar rates of TBI among population-based samples of returning Iraq veterans but nearly all affected veterans in these samples reflected mild TBI. Terrio and colleagues performed clinical assessments on roughly 4,000 recently returned Army soldiers and 22.8% were diagnosed with TBI (Terrio *et al.*, 2009). In an anonymous survey, Hoge and collaborators found that 15% of 2,525 returnees reported TBI during deployment (Hoge *et al.*, 2008).

Several studies have identified associations between TBI and mental health problems among returning US service members. In the previously mentioned study by Hoge *et al.* (2008) a dose–response relationship between severity of mild TBI and current PTSD was identified: 44% of soldiers reporting TBI with loss of consciousness met criteria for PTSD compared with 27% among those reporting TBI with altered mental status but no loss of consciousness, 16% among those reporting non-TBI injuries, and 9% among those with no injury. The figures meeting criteria for depression were 23%, 8%, 7%, and 3% respectively. In a study conducted in VA healthcare facilities, over 80% of the veterans who screened positive for TBI had comorbid psychiatric diagnoses (Carlson *et al.*, 2010). Of note, the screening tool used to help identify TBI in all of these studies remains un-validated.

Members of the Reserve and National Guard

Members of the Reserve and National Guard (Reserve/Guard), arguably face a range of unique ‘citizen-soldier’ stressors when they deploy. They must vacate and then return to another full-time occupation, often do not interact regularly with members of their unit prior to deployment, are often geographically remote from assigned duty locations, frequently do not deploy to the combat theatre in the same unit with which they train, and then lose unit integrity again on demobilization and return to post-deployment civilian life.

Empirical studies of Reserve/Guard troops confirm their relative vulnerability to the impact of deployment-related stressors. A study of psychiatric evacuees found that members of the Reserve/Guard were more likely to be evacuated for mental disorders (Rundell, 2006). Reserve/Guard members were found to have higher rates of mental health care use in the first 12 months after deployment (Kim *et al.*, 2010), and were more likely to report an increase in prevalence of mental disorders between 3 and 12 months post-deployment, compared with active-duty members with similar exposures (Thomas *et al.*, 2010). Additionally, Reserve/Guard personnel who deployed with combat exposures were also observed to be at increased odds for new-onset of heavy weekly drinking, binge drinking, and other alcohol-related problems,

whereas active-duty personnel who deployed with combat exposures were only at increased odds for new-onset binge drinking (Jacobson *et al.*, 2008). Finally, using longitudinal data from the DoD Post-Deployment Health Assessment and Post-Deployment Health Reassessment Programs, Milliken *et al.* (2007) found significantly greater increases in rates of screening positive for PTSD, depression, and other indicators of psychosocial adjustment issues among Reserve/National Guard versus active component troops.

Women deployers

Differences in mental disorder risk among deployed men and women remain somewhat controversial. A retrospective study of US Army soldiers deployed to Iraq and Afghanistan found that women were 1.6 to 3 times more likely to be diagnosed with a mental disorder (Wojcik *et al.*, 2009). Other studies have observed that female service members are at higher risk for new-onset disordered eating (Jacobson *et al.*, 2009), and sexual trauma (Haskell *et al.*, 2010; Kimerling *et al.*, 2010). However, sex differences affecting the association between combat deployment with PTSD and depression are less clear. While studies have found deployed women to be at increased risk for depression (Haskell *et al.*, 2010; Maguen *et al.*, 2010b; Wells *et al.*, 2010), a survey conducted among deployed US Army soldiers found similar rates for symptoms of PTSD and depression among men and women (MHAT-II, 2005), while another study found consistent two-fold increases for newly reported PTSD symptoms post-combat in men and women reporting previous physical and sexual traumas (Smith *et al.*, 2008b). With lines of battle poorly defined in current conflicts, men and women are exposed to similar combat-related stressors. Some hypothesize that findings of similar rates of PTSD and depression among deployed men and women are due to relatively equivalent combat-like exposures that confer similar risks among men and women for PTSD and depression (Hoge *et al.*, 2007a). Clearly, further research is needed to assess how sex differences may contribute to short- and long-term mental disorder risks associated with combat.

Psychological resilience

Psychological resilience, the ability to maintain relatively normal levels of mental and physical functioning following exposure to a traumatic event (Bonanno, 2004), is a challenge to define clearly, but has become increasingly studied and the focus of programmes that aim to foster improved deployment mental health outcomes. This has been made possible as much of the Iraq/Afghanistan deployment-related research is now conducted real-time, allowing findings to drive

prevention efforts. For example, one study showed that lower unit support and post-deployment social support were associated with increased PTSD and depressive symptoms, and decreased resilience and psychosocial functioning (Pietrzak *et al.*, 2009), while another study showed that the number of close friends or relatives decreased the risk for post-deployment PTSD in a group of US Marines (Phillips *et al.*, 2010). These observations are consistent with a study of Air Force medical personnel in which the authors concluded that unit cohesion protected against PTSD regardless of level of stress exposure (Dickstein *et al.*, 2010). Additionally, resilience to PTSD and/or depression following deployment appears to be adversely affected among those who reported childhood trauma (Cabrera *et al.*, 2007; LeardMann *et al.*, 2010), prior assault (Smith *et al.*, 2008b), or screened in the lowest 15% of functional health prior to deployment (LeardMann *et al.*, 2009).

While all the US services have had active mental healthcare initiatives and psycho-educational programming designed to improve service member adaptation (Bowles & Bates, 2010; Warner *et al.*, 2011), one of the hallmark changes during the current conflicts has been the US Army's introduction of a system of resilience training, which has evolved over time. In 2007, the US Army launched the Battlemind training system. Battlemind, developed by the Walter Reed Army Institute of Research, was grounded in research documenting the mental health costs of deployment to Iraq and Afghanistan, as well as the stigma associated with seeking treatment for mental health problems (Hoge *et al.*, 2004), the importance of the military unit in promoting resilience (Bliese, 2006), and the impact of leader behaviours on soldier well-being (Britt *et al.*, 2004). To date, three group-randomized trials conducted at post-deployment suggest the efficacy of Battlemind training (Adler *et al.*, 2007, 2009; Thomas *et al.*, 2007). Other studies documented the link between pre-deployment training and better mental health during deployment (MHAT-V, 2008). These encouraging findings demonstrate the potential feasibility of improving soldier mental health through resilience training, although effect sizes were small, consistent with public health-style interventions (Bliese *et al.*, 2011).

These research findings are also leading to programmatic change. In 2009, the US Army's senior leadership identified resilience as a top priority and launched Comprehensive Soldier Fitness (CSF), a new and broader programme that integrated a revised version of Battlemind training (now called resilience training) with material from the Penn Resiliency Program (PRP) (Gillham *et al.*, 2007) and the Army Center for Enhanced Performance (Casey, 2011; Cornum *et al.*, 2011). Despite the importance of service members receiving validated early interventions, research findings have not fully caught up with the need to

provide early intervention programmes in the current deployment context. Nevertheless, elements of the CSF programme have been validated, and the goal is to ensure that new resilience training material provided under this programme will only be incorporated after efficacy with soldiers has been established (Lester *et al.*, 2011).

Department of Defense and National Institute of Mental Health response

Of the 340,000 US active component and reserve component (the latter includes both National Guard and Reserves) service members completing the post-deployment questionnaires, approximately 5–10% were referred for mental health evaluation, and among those referred, approximately 95% recorded an inpatient or outpatient visit within 6 months of the referral date (MSMR, 2010). Roughly translated, this equates to somewhere between 16,000–32,000 deployed US service members who had one or more health care visits for a mental health evaluation during this 12-month period. The burden on the US military mental health community was also increased by the National Defense Authorization Act for fiscal year (FY) 2010, which required the DoD to implement person-to-person mental health assessments for each US service member who has been deployed in connection with a contingency operation (Assistant Secretary of Defense for Health Affairs, 2010).

The National Institute of Mental Health (NIMH) is heavily invested in studying the psychological consequences of war. During FY 2009, NIMH spent over US\$41 million dollars on 97 grants to improve the mental health of veterans (Insel, 2010). A promising area of NIMH-funded research has included early psychosocial intervention for PTSD symptoms using cognitive behavioural therapeutic self-management models delivered over a web-based interface and assistance from a health care provider or coach. Litz and colleagues tested this approach in a small randomized trial and found surprisingly robust effects versus a web-based supportive counselling control approach (Litz *et al.*, 2007). This group is currently nearing the completion of a second controlled trial in primary care patients with PTSD (Engel *et al.*, 2009). The patient is assisted by a primary care nurse, and it may be useful for military personnel who are ambivalent about seeking care from a specialist. Other NIMH research has focused on PTSD as a disorder of brain circuits needed to extinguish fear (Milad & Quirk, 2002), and on PTSD-related fear extinction as an active learning process (Bouton, 2004) that may be specifically aided by the partial N-methyl d-aspartate agonist called d-cycloserine (Guastella *et al.*, 2008; Hofmann *et al.*, 2006; Ressler *et al.*, 2004). NIMH-funded researchers are also attempting to identify genetic

biomarkers that may be associated with PTSD, and are exploring potential preventive pharmacologic approaches for PTSD (Insel, 2010).

Assessing long-term symptoms

Although not unique to the conflicts in Iraq and Afghanistan, many concerns remain about the long-term effects of PTSD and other war-related mental health conditions, especially when over 2 million US service members have deployed in support of these operations. For example, how do we best identify and monitor the continuum of risk behaviours that are associated with PTSD and co-occurring disorders? This is an important question given recent research findings that psychiatric disorders are a major risk factor for increased mortality among veterans (Chwastiak *et al.*, 2010). In addition, the family members of service men and women deployed to Iraq or Afghanistan appear to be at significantly increased risk for mental disorders and increased mental health service use (Mansfield *et al.*, 2010a; Mansfield *et al.*, 2010b). Similarly, recent research has shown that increases in PTSD symptoms among National Guard soldiers following deployment to Iraq were associated with poorer couple adjustment and greater perceived parenting challenges (Giwertz *et al.*, 2010). Thus, war-related psychiatric consequences may even cross generations.

Primary care is a promising early intervention opportunity for service members and veterans with PTSD. Civilian, VA, and military population-based studies suggest that at least half of individuals with PTSD remain untreated, sometimes for many years, and the reasons are complex (Hoge *et al.*, 2004; Kessler, 2000; Magruder *et al.*, 2005; Wang *et al.*, 2005). However, the average military service member makes about 3.4 visits to primary care annually (Engel, 2005) – even more often if they meet criteria for PTSD (Hoge *et al.*, 2007b). A growing scientific literature suggests that systems-based primary care approaches lead to improved mental health services and outcomes for common mental disorders including PTSD (Engel *et al.*, 2008). One military example is called RESPECT-Mil (Re-Engineering Systems of Primary Care Treatment for PTSD and Depression in the Military) and includes routine primary care screening for PTSD and depression, the use of a validated and efficient diagnostic aid for service members that screen positive, a nurse care management option for those diagnosed with depression or ‘possible PTSD’, and weekly psychiatrist review of care managers’ caseload that leads to electronic feedback recommendations to the primary care provider. A feature of RESPECT-Mil is its use of a web-based informatics approach (Unützer *et al.*, 2002) that helps ensure careful follow-up in care management, timely treatment changes for patients

failing to respond, and benchmarking reports to guide care managers and clinic leaders. Since the late 1990s, the US Air Force has run a different primary care-mental health model called the Behavioral Health Optimization Program that uses an embedded mental health provider to improve mental health service access (Munsey, C., 2009). A number of psychometrically sound screening tools, diagnostic instruments, and trauma and symptom severity scales are available to facilitate and augment the clinical assessment of PTSD and other disorders such as substance misuse, mood and anxiety disorders (Ouimette *et al.*, 2010; Weathers *et al.*, 2009).

Current and future burden on the Department of Veterans Affairs

In the USA, the VA is the leading agency for veteran’s health benefits, including healthcare, compensation and benefits for war veterans for service-related illnesses and injuries. The VA healthcare system includes over 170 medical centres, 350 outpatient clinics, and 125 nursing facilities. In her statement to the US House of Representatives Committee on Veterans’ Affairs Hearing (‘The True Cost of War’), Bilmes stated that as of October 2010, 2.1 million Americans have served more than 3 million tours, with more than 90,000 injured and 600,000 treated by the VA (Bilmes, 2010). Nobel prize economist Joseph Stiglitz and Bilmes co-authored an estimate of the direct and indirect societal costs of the conflicts in Iraq and Afghanistan (Stiglitz & Bilmes, 2008), at between US\$2 trillion and \$5 trillion, depending on how certain variables used to forecast cost play out over future decades. In Bilmes’ statement to Congress, the health-related costs of the war (veterans’ medical, disability and Social Security), mainly the purview of the Department of Veterans Affairs, were estimated at between \$589 billion and \$984 billion. Costs already substantially higher than the earlier estimate of \$422 billion to \$717 billion (Stiglitz and Bilmes, 2008) and due to higher than anticipated rates of VA health service use and veteran filed disability claims. Based on the experience after previous conflicts, these costs typically rise and peak at 30–40 years after the conflict, as veterans get older and have increased health care needs (Bilmes, 2010; IoM, 2010).

Rising rates of VA use since the Vietnam War are consistent with rising health-related costs of war. Since 2002, 41% of the 837,458 separated Iraq/Afghanistan veterans eligible for VA healthcare have enrolled in the VA (Kang, 2008), compared with only 10% of Vietnam veterans who had enrolled for VA healthcare 15 years after the end of that conflict (Kulka *et al.*, 1990). According to the VA Office of Public Health and Environmental Hazards, during 2002–2009, over 1 million Iraq/Afghanistan veterans left active duty, of whom 46% sought services from the VA, and 48%

of those who sought care were diagnosed with a mental disorder (Department of Veterans Affairs, 2010).

It is expected that the number of veterans presenting to the VA with mental health issues will continue to escalate over the coming years. This is due in part to continued Iraq and Afghanistan operations, multiple deployments (Kline *et al.*, 2010), and delays from onset of mental disorder to presentation for healthcare, and evidence of rising prevalence of mental disorders over time (Milliken *et al.*, 2007; Grieger *et al.*, 2006; Hoge *et al.*, 2006). For example, studies of US service members returning from Iraq/Afghanistan have found PTSD prevalence estimates of about 5% prior to deployment and 12% upon immediate return (Hoge *et al.*, 2004) and estimates of about 16% when surveyed one year after deployment (Hoge & Castro, 2006). Milliken *et al.* conducted a longitudinal study of soldiers, collecting PTSD prevalence information within one month and 4–10 months after deployment, and observed prevalence increases from 11.8% to 16.7% for active duty and 12.7% to 24.5% for Reserve/Guard (Milliken *et al.*, 2007). Bliese *et al.* conducted a matched study of 509 soldiers returning from combat in Iraq and results showed an increase in mental health problems at 120 days post-deployment in comparison to immediate reintegration (Bliese *et al.*, 2007). Finally, when Congress passed the National Defense Authorization Act of 2008 it increased the period of automatic healthcare coverage of all combat veterans from 3 to 5 years post-deployment, a move designed to ensure health benefits for demobilized reserve component service members. Demobilized Reserve/National Guard are not entitled to DoD healthcare system coverage beyond six months after demobilization or when subsequently mobilized to active military duty. These observations suggest that the VA may see a substantial increase in veterans' future medical and disability benefits healthcare seeking among Iraq and Afghanistan veterans.

In response, between FY 2009 and FY 2010 the VA increased core mental health staffing by 8%. Since 2004, the VA has conducted universal post-deployment mental health screening of Iraq/Afghanistan veterans receiving VA care. Beginning in 2005, the VA initiated an aggressive expansion of mental services capacity, including embedding mental health providers in primary care settings along the lines used in RESPECT-Mil and the Behavioral Health Optimization Project so as to reduce the effects of stigma and improve veteran access to mental health services (Hoge *et al.*, 2004; Zeiss & Karlin, 2008). Moreover, the VA is in the process of nationally disseminating and implementing evidence-based psychotherapies (EBPs) for PTSD, depression, and serious mental illness. Two EBPs for PTSD that the VA is currently disseminating—cognitive processing therapy (CPT) and prolonged exposure (PE) therapy—are augmented with the

placement of a part-time EBP Coordinator at each VAMC to serve as a champion for EBPs at the local level (McHugh & Barlow, 2010). As such, a February 2009 survey of VAMCs that assessed the extent to which CPT and PE were being provided to Iraq/Afghanistan veterans with PTSD revealed 94% of medical centres were providing CPT or PE, and 72% providing both.

Conclusions

There is a substantial body of literature to support a robust relation between exposure to combat and mental health outcomes, especially PTSD as well as head injuries, which includes TBI. It is unlikely that prevalence rates for mental disorders, such as PTSD have changed much from conflict to conflict. Prevalence rate estimates for PTSD among US service members serving in the era of the Iraq and Afghanistan conflicts have ranged from 12% of anonymously surveyed US Army combat troops, to over 20% among those seeking healthcare in VA settings. For the first time, military and VA researchers are estimating the mental health effects of military service and the needs of service members, families, and veterans nearly in real-time, allowing findings to have a rapid impact on mental health programmes and services aiming to improve resilience of US forces and mitigate the adverse mental health effects of war on those previously deployed. Despite gains to date, there is still enormous progress yet to make in areas such as effective treatment, improved understanding and reduction of chronicity, and mental health comorbidity. As mental health needs continue to mount for both DoD and VA, leaders from policy, research, and clinical realms will surely face increasingly difficult challenges and decisions, not the least of which will revolve around rising healthcare costs and the fiscal reality of finite resources in a time of national deficit spending.

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14. ABSTRACT Although documentation that war inflicts psychological casualties dates back to the American Civil War, most research began after the Vietnam conflict, when studies focused primarily on posttraumatic stress disorder (PTSD). With ongoing conflicts in Iraq and Afghanistan, there has been significant research to illuminate the epidemiology of war-related psychological casualties. Significant findings include an appreciation for the role combat plays in the development of mental disorders, including PTSD, depression, alcohol misuse, somatic symptoms, and others. Recent research has endeavored to understand and improve psychological resilience to temper the negative effects of combat on mental health. With over 2 million US service members involved in the Iraq/Afghanistan conflicts, military mental health practitioners have observed a dramatic increase in the number of US service members who have obtained care. Additionally, the Department of Defense has aggressively worked to improve mental health care. The Department of Veterans Affairs has seen increases in veterans seeking care for mental disorders, and it is adapting staffing levels to meet current and future needs. Scientists will continue efforts to better understand the determinants and prevention of combat-related mental disorders, and they will work with clinicians who strive to improve services and treatment modalities for veterans.
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