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Chapter 8

The Returning Warfighter: Advice for Families and Friends

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The Returning Warrior: Advice for Families and Friends

This chapter is written primarily for families and friends of those returning from war and for clinicians who are assisting them. The chapter identifies issues that frequently emerge in re-establishing relationships after a combat deployment. General information and advice are offered for relationships that are undergoing the normal strains of readjustment. Specific resources are identified for relationships that may need more formal intervention.

The Returning Warrior: Advice for Families and Friends

Your loved one has survived the war. You rejoice that they are coming home. You know they have experienced the horrors of war, but you are confident that the warmth of your love will sustain them and will sustain your relationship. You eagerly anticipate life and your relationship getting back to “normal” after their return. Conceivably, it could work like that, with all the pieces falling effortlessly into place. In many—perhaps most—cases, readjustment requires more deliberate effort, flexibility and sensitivity to the impacts of combat service.

This chapter is designed to provide guidance to families and friends of those returning from war, and to clinicians who are supporting them through the readjustment process. (Clinicians may also want to refer to Galovsky & Lyons, 2003, a paper that addresses the same issues with a focus on the pathological end of the spectrum.) The chapter will address some of the challenges that emerge as veterans, friends and families try to pick up where they left off. Some problems tend to be common across individuals so can be discussed as specific examples. Other difficulties are more idiosyncratic, but still tend to share some of the same underlying principles. By examining those principles, this chapter aims to take the reader beyond merely acknowledging that post-homecoming frictions are normal and predictable. The goal is to help identify specific situations that are likely to increase such frictions so that you can choose to avoid entering into such circumstances or can proceed with informed preparedness. Armed with such insight, it is easier to avoid misinterpreting tensions as a sign of deteriorating commitment and caring, and recognize them instead as predictable responses to certain sets of cues that may have nothing to do with the quality of the relationship. The first

half of this chapter presents tips derived from the author's two decades of work with veterans and their families in clinical and non-clinical settings. The second half of the chapter presents information on more formal clinical resources that may be needed if problems are severe or persistent.

The Warrior

The term "warrior" is controversial, often deemed politically incorrect. However, it is deliberately used in this chapter to highlight that the experience of war does change a person. A persona and reaction style become engrained and remain forever a part of that individual—sometimes a minor component of the individual's character, deeply buried and rarely glimpsed; sometimes on the surface and "in your face", the defining essence of that individual for years to come.

To survive in a combat zone, a level of hyper-vigilance and suspicion is mandatory. The most innocuous-looking individual or item can prove to be the most deadly. Tendencies for sympathy and compassion are often used as lures to entrap the unwary—pick up the injured child and the booby trap goes off, try to get to the wounded comrade and find oneself in the crosshairs of the sniper. Losses are often inevitable. Choices may be limited to several unacceptable options, forcing the warrior into actions that run directly contrary to prior values and beliefs. The warrior must build a wall around tender emotions to be able to function in a calculated, all-about-business manner to stay alive and not jeopardize other comrades. A quiet moment to fully mourn a lost friend or the opportunity to stop to aid a wounded civilian are luxuries that are often not available when there are so many other demands at the same time. Working through exhaustion, filth, hunger and thirst can become routine. To keep alive and perform

combat duties successfully, the individual may have to remain in this combat mode 24-7, dozing only lightly, ready to pounce into attack mode at the slightest signal. After enough time and practice, this combat mode becomes second nature. The pattern does not fully shut off even after the person is home and safe.

Recognizing and Anticipating Common Problems

The intensity of this combat-ready stance does diminish with time. However, certain circumstances can reactivate it to full intensity with little warning. Learning to anticipate such circumstances in advance and quickly recognize them when they occur without prior prediction can be a powerful asset for loved ones. The next three sections will present a variety of common situations in which the combat mode is re-evoked and aspects of the warrior persona collide with the role of lover, family member and friend.

Individual Relationships and Private Settings

Family and friends eagerly await the return of your loved one. You are excited to show off accomplishments, although perhaps with some uncertainty of how they will like certain changes or how the relationship will readjust. However, when your loved one arrives, his/her emotional focus seems scattered or erratic.

The returning warrior may feel relief and happiness to be home and joy at reuniting with loved ones. This may be mixed with insecurities about readjustment, guilt or shame for combat decisions and actions, survivor guilt and concern for those still in the battle zone, and/or confusion regarding their own values and character. Things previously valued may now seem trivial, even irritating. Other things may take on increased significance, to a point that may seem irrational (never letting the gas gauge fall below half a tank, veering widely around seemingly-harmless debris in the road, always

having an escape route planned, insisting on always knowing the whereabouts of loved ones). Roles that shifted during separation may need to be renegotiated. Relationships that became idealized in memory during months of separation may seem tarnished in the light of reality. Under such pressures and with high expectations on both sides, the potential for unintended slights and open clashes is high (Knox & Price, 1995; Peebles-Kleiger & Kleiger, 1994).

One of the most significant areas of conflict pertains to talk about the war. There is almost invariably desynchrony in the warrior's readiness to discuss combat experiences and others' eagerness to inquire about such experiences. Particularly outside of military environments, well-meaning friends and family may jovially ask about kills and conquests. Those who are more accustomed to military culture or simply more sensitive in their approach may find that even modulated inquiries of "What was it like?" can spark angry replies. You soon learn not to ask, or to even avoid the topic at all costs. Weeks, months or even years later when the warrior feels psychologically ready to share some of those war memories, the sad fact is that most people no longer want to listen. At that point, attempts the warrior makes to bring up the topic may be rebuffed with well-intended advice to "put that behind you" or less sympathetic commands to "get over it".

In addition to the issue of timing, there is another aspect of discussing war memories that damages many relationships. Do you harbor hurt or resentment that the warrior seems unwilling to share these stories with you? Many family members do not realize that the level of emotional confusion about events can take time to sort out before the stories are even in any organized fashion to tell. Warriors are likely to have some insecurity about whether they will still be viewed the same after they reveal what they

have seen and done. (For an in depth discussion of the complex array of issues involved when a warrior confides atrocities, readers are referred to a classic 1974 paper by Haley.) Many warriors remain reluctant to share their stories with loved ones not for lack of trust or intimacy, but because they do not want to infect loved ones with the same nightmarish images that haunt them. Such concerns reflect a real risk, as secondary traumatization is a phenomenon seen among therapists (Figley, 1995), partners (Dekel, Goldblatt, Keider, Solomon, & Polliak, 2005; Maloney, 1988) and children (Ancharoff, Munroe & Fisher, 1998). Partners sometimes contribute to the tension by becoming jealous or resentful that the warrior shares these stories with a counselor instead, not realizing that it is precisely the LACK of caring as much about the counselor or about the counselor's reaction that makes this possible.

The warrior may find it easier to share experiences with others who served in combat, even if they are strangers. The stories can be told in military shorthand without the necessity of explaining and elaborating. There is less fear of being misunderstood if the others also engaged in comparable experiences. This can facilitate conversations with family and friends who are also veterans. This would seem to be an advantage, but it does not always outweigh the challenges inherent in the warrior persona. Studies of father-son pairs who each experienced combat trauma have reported that sons of combat veterans adjusted less well to their own combat trauma than the sons whose fathers had not experienced war trauma (Rosenheck, 1985; Rosenheck & Fontana, 1998).

If you are not a veteran, one way you can prepare yourself for similar discussions—or, alternatively, reduce your own need to push for such a discussion—is to familiarize yourself with the combat events the warrior's unit might have experienced.

Asking others who served in that unit would likely risk resentments and is generally not recommended. However, written information is available. After the Vietnam war, a book authored by the wife of a Vietnam veteran (Mason, 1990) served as a central reference for such information. Now, the internet provides a wealth of information about contemporary war experiences. TIME magazine (Bennett, 2005) reviewed various blogs by troops in Iraq and recommended several as offering a range of first-hand accounts of life in the war zone. A Web search for “Iraq blog” (or “Afghanistan blog”, etc.) will pull additional/updated sites to peruse. Be prepared for crude language and explicit descriptions or pictures.

If you feel uncertain of how a discussion of war events might unfold, Johnson, Feldman, and Lubin (1995) offer very helpful case examples of ways to facilitate positive communication once the warrior is ready to disclose personal trauma experiences. Resist the desire to jump in and “fix” the hurt—focus on listening. Premature reassurances can be meant to comfort but can leave the warrior feeling that the degree of emotion or the complexity of the moral dilemma was dismissed.

Emotions about things unrelated to war have no immunity from the changes war imparts. After learning to shut off emotions to be able to carry out the cold priorities of combat, re-learning to risk the emotional vulnerability that intimacy requires does not come easily. This may come across as uncaring and uninterested. Restless sleep may lead to separate bedrooms and further reduce intimacy. Try to be patient and not over-interpret such changes or take them too personally. Be forewarned, however, that such emotional numbing/withdrawal presents one of the biggest challenges to personal relationships (Frederikson, Chamberlain, & Long, 1996; Riggs, Byrne, Weathers, & Litz,

1998; Wilson & Kurtz, 1997), including those with children (Ruscio, Weathers, King, & King, 2002).

It may come as a surprise to loved ones that the warrior's political, social and religious views may have changed and may now contrast with those held by loved ones who remained stateside. Folks at home have not had access to the views and experiences of the war zone, whereas those overseas have been cut off from local developments and local opinions while away. Views on the war itself may be a particularly volatile subject. Loved ones may be baffled and irritated by the warrior's strident yet sometimes internally-inconsistent views. Be aware that conflicted thoughts, like conflicted emotions, can take time to sort out. Some of the views the returning warrior espouses may be concepts that are being "tried on for size" –not necessarily the viewpoint the warrior will settle on after the sifting process is complete.

Problems in Public Settings

A huge welcome party is planned but the warrior acts reluctant to attend. Ditto the big weekend of the warrior's favorite sporting event. You ask what is wrong but get a vague reply. The warrior agrees to go, but then is irritable and disappears partway through the event. You ask what is happening.

Many group functions--such as parties, clubs and most sports events--involve crowded venues with heightened levels of activity and noise. For someone still in combat mode, it can be exhausting to try to monitor everything going on in such a busy environment. Fireworks present a particular challenge, especially if the warrior is not in a position to observe them being lit (observation allows some ability to predict the flashes and booms). Quiet, stationary events (such as a classical concert, movie, or worship

service) can also be problematic. A restless warrior's own fidgeting becomes conspicuous and a premature departure is disruptive to others. Thus, cut off from a timely escape route, such a setting can feel oppressive. In either case, the warrior can become frustrated by their own inability to relax and enjoy the activity, feeding the likelihood of irritability.

Restaurants may be somewhat easier to readjust to, but any public gathering spot still is recognized as a potential target. Thus, the warrior may be insistent on positioning him/herself to see everything that is happening. The warrior may not recognize that this seating arrangement is apt to leave a dining partner facing the wall on every outing.

Even when things are going smoothly, there can be potential for sudden volatility. A heightened emotional reaction to discussions of politics and questions/comments from others is common during the early days at home. With images of the combat zone still fresh, the newly-returned warrior may have difficulty inhibiting a response when hearing others express "uninformed" views.

Fluctuations in Problems

It is normal for reminders of combat to stir a temporary increase in anxiety or moodiness. The anniversary of a battle and weather that is similar to the combat zone are common reminders. Current news events such as the rubble and evacuees from hurricanes and tsunamis may remind the warrior of the devastation of war. Personal life events can also serve as cues. A promotion can be disquieting for someone who felt responsible for an operation that failed under their command. Births and other children's milestones may also elicit ambivalence—pride and joy mixed with feeling undeserving of parenthood after being involved in deaths of other children or their parents.

One of the coping strategies many warriors adopt is to keep occupied so that their mind has no time to wander back to combat scenes and so that they are tired enough to sleep through the night without combat dreams. In many cases, this strategy serves very well until either a chronic illness or retirement leads to a more sedentary pace. In such cases, developing alternative ways to occupy time and thoughts is often all that is needed.

Resources and Services

Counseling and mental health services are available to help shore up relationships that have been strained by deployment and war experiences. If the warrior remains actively involved in the military, a variety of family support services are usually available through their unit. The Department of Veterans Affairs also offers services at medical centers, community clinics and Vet Centers. The following website provides a good starting point to learn about services in your area:

<http://www.va.gov/rcs/VetCenterDirectory.htm>.

The extent of family services is expanding as the need becomes increasingly apparent. During the Gulf War in 1991, Reserve and Guard units offered deployment support groups on a scale not previously seen. Since that time, homecoming preparation and post-homecoming services have been expanded across branches of the military. Engaging families in the veteran's treatment was identified as one of seven Department of Veterans Affairs (VA) "priorities of quality" for clinical services (VHA Directive 2001-00610). The VA subsequently launched major initiatives to expand services for families.

Particular emphasis has been given to veterans who remain especially mired in the warrior role, i.e., those diagnosed with posttraumatic stress disorder (PTSD). PTSD is a

psychiatric disorder in which a person frequently relives a horrific, life-threatening event via nightmares, repetitive thoughts and images, or even acting as if the event was happening all over again. One study (Riggs et al., 1998) found that only 30% of couples report relationship distress if the veteran does not have PTSD. However, if the veteran has PTSD then the odds reverse and only 30% of couples do *not* report distress. The severity of the PTSD symptoms is correlated with the severity of relationship distress. A similar pattern is reported by Dirkzwager, Bramsen, Ader and van der Ploeg (2005), although the percentage of relationships classified as problematic is lower (16% in couples without PTSD, 26-39% in couples with varying degrees of partial or full PTSD). The presence of PTSD is also associated with lower happiness and less life satisfaction (Jordan et al., 1992) and somatic and sleep-related complaints (Dirkzwager et al., 2005) in the veteran's spouse. Studies have also found children to be negatively impacted by a father's PTSD (Caselli & Motta, 1995; Davidson, Smith & Kudler, 1989; Rosenheck, 1986; Rosenheck & Nathan, 1985), although other variables such as family violence (Harkness, 1991) or the father's participation in atrocities (Rosenheck & Fontana, 1998) are sometimes better predictions of problems. Some studies show that parents and/or siblings are less affected than partners by the warrior's PTSD (Dirkzwager et al., 2005; Lyons & Root, 2001). However, data from Dirkzwager and colleagues indicate a greater effect on mothers than fathers. Given that studies to date have focused almost solely on male veterans and female partners but have generally combined across genders when looking at parents and siblings, it is possible that the effects on other female family members have been underestimated. As more women are serving in combat zones, future

studies can be expected to help elucidate gender-specific effects PTSD may have on various family relationships.

Effective therapies are available to treat PTSD. *Journal of Clinical Psychiatry* published treatment recommendations compiled by a panel of experts (Foa & Davidson, 1999). These guidelines include a synopsis written specifically for patients and families. More technical information for clinicians is available in a textbook by Foa, Keane and Friedman (2000). Many of the therapies used to treat PTSD are very effective, earning an “A” rating on the A-F scale employed in the text by Foa, Keane and Friedman, indicating that the evidence supporting their use is from well-controlled, randomized clinical trials.

For more information about trauma, PTSD, and their effects, there are several good resources easily available. A 29-minute videotape titled *PTSD: Families Matter* (Abrams & Freeman, undated) depicts issues families encounter when a veteran has PTSD. It was developed by VA’s South Central Mental Illness Research, Education and Clinical Center (MIRECC) and is available to licensed clinicians by contacting Michael.Kauth@med.va.gov. A video entitled *Living with PTSD: Lessons for Partners, Friends and Supporters* is accessible at the website www.giftsfromwithin.org. The National Center for PTSD (2005) offers an online fact sheet for families at www.ncptsd.va.gov/facts/specific/fs_family.html. A free 102-page booklet titled *Veterans and Families’ Guide to Recovering from PTSD* (Lanham, 2005) provides helpful information, including essays by veterans and family members and a resource directory.

There are often hurdles to surmount in accessing care (Glynn et al, 1999; Lyons, 2003). Specialized care may be a distance away. Scheduling and transportation can be problematic. There may be bureaucratic red tape to establish eligibility. There may be out-of-pocket costs. For the warrior, the mere idea of talking about the traumas can present the largest barrier. If PTSD symptoms are present, it is important to do whatever you can to help overcome these barriers. PTSD-related symptoms tend to expand if left untreated, as the traumatized person will go to greater and greater lengths to avoid re-experiencing the memories. This can lead to sleep avoidance, substance use, anger and violence (to deflect deeper feelings of hurt and loss). Left untreated, the traumatized person can skip from job to job and relationship to relationship, trying to outrun negative thoughts and feelings.

Family and friends play a major role in recovery from PTSD. Negative family relationships account for nearly 20% of the variance in PTSD treatment outcome (Tarrier, Sommerfield, & Pilgrim, 1999). However, two particular aspects of PTSD are very easy for loved ones to misinterpret, and thus risk undermining treatment. First, it is common sense to think treatment is supposed to make someone better and that if symptoms get worse after beginning treatment, treatment should be discontinued. However, the treatment for PTSD often involves focus on the traumatic event so that the conflicted thoughts and feelings associated with it can be resolved. Thus, during the initial phases of treatment, increased combat-related thoughts, dreams and anxiety are expected and can actually signify progress. The second common misinterpretation was mentioned previously but bears repeating in this context. When you are already frustrated that your loved one is more emotionally withdrawn and will not talk with you about what is

bothering them, it can be upsetting to learn (or suspect) that they are baring their soul to a perfect stranger (the therapist). Keep in mind that reluctance to divulge horrible details may be due to the importance of your relationship—not an indication to the contrary. Being aware of these counterintuitive aspects of PTSD therapy may help you resolve any ambivalence you may have about the warrior seeking or continuing treatment.

Successful treatment is in the best interest of all concerned, as untreated or incompletely treated PTSD can remain chronic over many years. In such cases, the emotional drain on families can be extreme (Beckham, Lytle, & Feldman, 1996; Sautter et al., 2006). Recognizing the impact on loved ones, there are treatments available that include them as well. In a review of marital and family therapies being offered in the wake of trauma, Riggs (2000) identified two major approaches to PTSD-related family/marital treatment: systemic and support. Systemic approaches treat the relationship to reduce friction and/or strengthen bonds. Traditional marital and family therapies would be in this category. Support treatments are those that have the goal of increasing social support for the warrior and the warrior's treatment. Support treatments often include teaching about PTSD symptoms and helping family members develop ways to cope with the warrior's PTSD symptoms. In the A-F rating system used to evaluate the strength of the evidence in support of various therapies, Riggs rated marital and family therapy for PTSD an "E". This rating reflects Riggs' judgment that the interventions are derived from long-standing clinical practice by a certain groups of clinicians but are not in widespread use and have not been empirically tested for use with PTSD. Such interventions are recommended by Riggs as supplemental approaches to the primary emphasis on treatment of the warrior's PTSD.

Since Riggs collected data for his review, Glynn and colleagues (1999) published a study in which behavioral family therapy was provided in addition to exposure therapy for the warrior. Riggs would categorize this study as support treatment, given the emphasis on coping skills training with the primary outcome of interest being reduction in the warrior's PTSD symptoms. The family therapy package included three sessions of orientation and evaluation, two educational sessions about PTSD and mental health treatments, then 11-13 sessions focused on skills training (communication and anger control, with a major emphasis on problem solving). The 11 veterans who received both exposure and family therapy achieved approximately double the reduction in PTSD symptoms that the 12 veterans who only received exposure therapy attained. However, this difference was not statistically significant. Glynn et al. (1995) provide a more detailed description of interventions evaluated in the 1999 empirical report, including case examples. The 1995 publication also provides recommendations for dealing with avoidance behaviors, physical aggression, substance use, alexithymia, and disclosure of combat experiences during behavioral family therapy.

Monson, Schnurr, Stevens and Guthrie (2004) recently published data from a pilot study of seven couples. In each case, the husband was a Vietnam veteran with diagnosed PTSD. Three of the seven men had previous divorces. The primary outcome of interest was the man's PTSD severity. However, the cognitive-behavioral couple's therapy that was administered (further detailed in Monson, Guthrie & Stevens, 2003) also included a strong systemic emphasis. In addition to two psychoeducational sessions about PTSD and associated relationship problems, this 15-session manualized treatment also included communication skills training and several cognitive intervention sessions targeting the

maladaptive patterns associated with the warrior mindset described previously. Results are mixed, with some veterans reporting deterioration in their relationship and increased PTSD whereas others reported improvement. Ratings by the clinicians and wives were more positive, as were veterans' reports of reduced anxiety and depression. The small sample size and lack of a comparison group or multiple baseline limit interpretation of these findings. However, this pilot project effectively sets the groundwork for larger controlled studies.

Neither systemic or support approaches focus solely on the needs of the family member. Recent studies indicate that loved ones, particularly spouses and other partners, are seeking precisely that piece that has been missing—help for themselves. A survey was conducted at workshops held for families of veterans who were in treatment for PTSD (Lyons & Root, 2001). Non-spouses (children, parents, siblings, friends) reported that their role in helping the veteran deal with the PTSD symptoms was limited and they indicated interest in the types of supportive and systemic services that had traditionally been offered. However, the 30 spouses who completed the survey reported a much different pattern. They described a very active role in helping the veteran manage PTSD symptoms, rating their role as large or “very large...more than the treatment team”. They spoke of helping the veteran get to appointments and remember medications, orchestrating the family's lifestyle around the veteran's symptoms to minimize relapses, and taking on roles that the veteran was no longer able to fulfill. Many spouses discussed the difficulty of working outside the home as the primary breadwinner plus inside the home as the primary caretaker for children, aged parents, and/or the veteran. Most had read about PTSD and talked to many providers or organizations about the disorder.

While approximately one-third of the spouses expressed some interest in systemic therapy to improve their relationship or reduce shared stress, they reported no desire for more informational sessions about the veteran's illness. What they did request, often with a tone of desperation, were therapies that emphasized the spouse's own needs. They voiced numerous requests for treatments to reduce the spouse's own stress level (not limited to stress that came from the veteran's PTSD symptoms). Many spouses wanted social activities to offset the isolation they felt.

A broader phone survey was conducted to test these findings (Sherman et al., 2005). Eighty-nine female partners of male Vietnam veterans disabled by PTSD were asked to describe services that could help them "better support their loved ones". Even with such other-focused wording of the question, the three interventions most commonly requested involved only the partner, not the veteran. Fifty-four percent requested a partners-only group. Twenty percent asked for more information about trauma and PTSD. Nineteen percent requested individual therapy for themselves. Only thirteen percent sought couple's therapy.

The search for services for themselves reflects the level of personal need these partners feel. The level of caregiver burden they report is extremely high, and is correlated with feeling incapable of controlling the veteran's emotional difficulties or their own coping with his symptoms (Sautter et al., 2006). Their ratings of burden also correlated with their reports that numerous barriers reduced ready access to clinical care – distance, cost, bureaucratic hurdles, etc. Such barriers may vary from one community to another (Lyons & Root, 2001). In an effort to reduce barriers, home-based interventions are being developed that may be supplemented with phone contacts (Lyons, 2003). Books

such as those by Mason (1990, 1998) and Matsakis (1996, 1998) constitute solid self-help options.

The Positives

We all progress through various stages in our lives, with a series of developmental tasks to accomplish as we mature (learning to develop relationships, becoming self-supporting, etc.) Under normative circumstances, we do not encounter deaths of numerous others and face the possibility of our own death being immanent until late in life. In combat, death is a frequent threat. Facing death so much earlier in life than most people can lead to an acceptance of mortality or numbing of reaction that can appear cold and uncaring. Many families, however, are surprised to see how the warrior shines in times of family or regional tragedies. Combat mode kicks in and the warrior may gear up quickly in time of crisis, efficiently drawing on the skills and coping developed during war to remain calm and task-focused when others are more flustered.

Many who survive the horrors and rigors of war emerge with a new clarity of their own abilities and limitations, a strong sense of values and beliefs, and an ethical maturity that many others do not develop until old age—if then. An entire research field is blossoming focused on the resilience and post-traumatic growth displayed by survivors of war and other traumas (Tedeschi & Calhoun, 2004). Like other survivors, many warriors are successful in imparting some of these survival skills and values to loved ones, helping them develop these characteristics without having to endure the trauma of combat in the process.

The emphasis in this chapter has been on how war changes the warrior. Concurrently, however, partners, children and others can also change. You may have

stretched from old roles and taken on new challenges. You may now long for additional changes or you may be eager to resume familiar patterns, all the more appreciative of tried-and-true traditions within your relationship. Regardless of the direction of change, keep in mind that the relationship will also have to adjust to accommodate to the new you, just as the relationship has to adjust to accommodate the warrior. It is true that the old status quo will be difficult (if not impossible) to reinstate, but doors will be open to many new possibilities.

Conclusion

The pressures of war leave a lasting imprint on the warrior. Much of it can be positive, but it can also create hurdles for loved ones. The warrior and loved ones will always be the key players in shaping the future potential for their own relationships. It is hoped that the patterns identified in the first half of this chapter will help your relationship weather the storm. The resources described in the second half of the chapter provide a starting point if more in-depth assistance is needed. Although there is no clinical magic that can undo the impact of separation and the experiences of war, clinical resources are available and can help. If you are concerned about the direction your relationship is headed, contact a counselor (<http://www.va.gov/rcc/VetCenterDirectory.htm> can help you locate local resources). It is much easier to restore a relationship if problems are addressed before they multiply.

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