Chapter 13
Considerations in Working with Veterans During COVID-19: When the Battle Is at Home

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Introduction

US veterans are uniquely poised to manage a global crisis when it arrives on their doorstep. Their reservoirs of crisis response skills honed in the military have broad applications to managing a pandemic like COVID-19. However, like many people in the world, some veterans struggle with the sudden threat of an invisible and deadly virus and the accompanying major changes to activities of daily life. For some, their time in active combat overseas did not prepare them for the experience of fighting an enemy at home that endangers everyone they love. Moreover, the particulars of the pandemic can trigger veteran-specific emotional vulnerabilities. This chapter discusses my personal and professional experiences working with US combat veterans from the Iraq and Afghanistan wars and reflects on the key resiliencies these veterans possess in adaptively facing a pandemic crisis while highlighting unique pandemic stressors triggered for some in the combat veteran population.

It should be noted that this chapter is being written in the midst of the pandemic and that the veterans discussed saw active combat in the Iraq and Afghanistan wars and lived in New York City at the time of the pandemic outbreak. This biographical information is an important context throughout the discussion. The former fact places their age range between mid-20s and late 30s and means they were involved in a war that is ongoing. Living in New York City at the outbreak might separate the experiences of these veterans from other veterans in the United States in some ways. Several of the veterans still actively serve in the National Guard or the Reserves, which were called on to respond to the crisis in New York. As one of the first big cities to have a coronavirus outbreak in March 2020, New Yorkers had limited
information about how the virus spreads, what public health safety measures needed to be enacted and what that would logistically look like, what impact the pandemic would have on food and provisions supply chains, and how long it would go on for. At one point there was a rumor that in an effort to contain the virus from spreading out of New York, all bridges and tunnels would be closed, essentially marooning the residents on four of the five boroughs that are islands. New York City quickly became the world epicenter for virus infections, calling on many everyday New Yorkers, from nurses and emergency responders to bodega owners and transportation workers, to become frontline workers and placing further strain on resources. In the succeeding months while still fighting the coronavirus, New York City would also become one of the primary cities with anti-racism and police brutality protests that triggered mass gatherings of people and the deployment of police and other security forces. In June 2020, reports of random fireworks detonations occurring throughout the city caused such distress to some residents that they protested at the mayor’s house in the middle of the night. Finally, in the past 19 years, New York City suffered two major disasters, one man-made with the terrorist attacks of September 11, 2001 and one natural disaster with Hurricane Sandy in October 2012. Some of the veterans in this chapter joined the military in response to September 11, and many suffered personal losses in the two disasters.

Resilience and Posttraumatic Growth

In many ways the veteran community is uniquely equipped to handle a pandemic. Their extensive training is specifically aimed at assessing and responding to crises and danger both logistically and mentally (Russell and Figley 2013; Grossman 2007). Their military work required a significant ability to gather information, plan, and anticipate short- and long-term consequences. In the first days of shutdown in New York City, many of my clients were more animated than usual, connecting with friends still in the military and the Reserves, gathering critical information that was scant at the time, and laying out possible scenarios and action plans. A common refrain was, “I’ve seen how things like this unfold.” It was also an opportunity for me as their therapist to witness certain organizational and initiative-taking characteristics that I had not previously seen in our work. This is discussed further in the “Clinician Self-Disclosure” section.

Military training and deployment often involve long periods of time away from family and loved ones. Therefore, veterans have already navigated long-term distance from loved ones similar to what stay-at-home orders required. Additionally, certain aspects of military training and missions require personnel to be isolated or on their own. As one veteran put it to me, “I’ve spent a lot of time alone in a field.” In early conversations during the pandemic, we itemized the techniques they used to cope with isolation and boredom on missions. While there is significant focus on posttraumatic stress injuries in veterans, many veterans also benefit from posttraumatic growth, which are character traits and adaptive perspectives that are formed
or strengthened as a result of navigating traumatic experience (Tedeschi and Calhoun 2004). Examples of posttraumatic growth attributed to some military service include pride, appreciation of life and liberty, deep and loyal bonds, as well as positive feelings of accomplishment and self-efficacy (Russell and Figley 2013). Many of the veterans were pleased to realize the ample skills they already had in their tool chest, and some started sharing their coping skills with loved ones managing social isolation and traumatic stress for the first time. As pictures and stories of honorable deeds of everyday Americans were published, veterans also took solace in the courage and compassion of their neighbors. One veteran commented, “When I see people selflessly helping each other, it makes me proud to be an American, and proud of my service.”

The Threat at Home

Perhaps the primary and most immediate difference the veterans I work with noticed between the pandemic and combat was summed up in the statement, “This time my family’s in danger.” As intense as active combat and lengthy deployments were, my clients recognized that there was comfort in knowing the danger they faced was not experienced by their loved ones. While in the pandemic they had concerns for their personal wellness and safety, worry over their loved ones triggered emotional struggle and a sense of helplessness anathema to people who take pride in their identity as protectors (Russell and Figley 2013). This was made worse by the global scale of the pandemic, which put every one of their loved ones in harm’s way and thwarted contingency plans of trying to move loved ones to safety. Moreover, as the pandemic spread and stay-at-home orders took effect, some veterans struggled with the idea that “nowhere is safe or the same anymore.” Many veterans appreciated that despite what they witnessed in combat, “home” was still relatively safe and would be there when they returned. Remembering his long stretches of deployment, a veteran said, “I would always think, ‘If I make it through this, then there’s home at the end of the tunnel. All the great things about life are there and waiting,’ and everything was amplified because you knew it was still there. Now home isn’t the same. What’s waiting at the end of this pandemic fight?”

The struggle of deferring their role as the protector to medical personnel and other essential workers was more acute for the veterans whose loved ones filled these roles. Some veterans were distressed by the idea that not only were loved ones in danger, but they were also not in industries trained to come together and confront a crisis the way veterans could rely on their units and commanders. One veteran started calling her aunt daily who works in a grocery store, running a check list of precautions and becoming frustrated when her aunt did not think such safety measures were necessary, contrary to what the veteran was seeing in New York. Another veteran was beside himself with worry as his nurse practitioner wife went to work in one of the hospitals hit hardest by COVID-19 while he worked from home and cared for their son. His concern was compounded by his wife being 8 months
pregnant with their second child. With tears in his eyes he kept saying, “I’m the one who is supposed to go into danger, instead it’s my wife and child. I’m supposed to protect them. It’s not right.”

While worried for family and loved ones, especially those in essential jobs, some veterans took issue with referencing these jobs as being “on the front line” and referring to New York as “a war zone.” These veterans acknowledged the difficulty and fear of the unique situation but felt the nomenclature normalized their experience of war instead of its intended purpose of highlighting how serious the situation was in some areas. Hearing and reading these combat-specific phrases served as one of many triggers during this time.

### Posttraumatic Stress Triggers

In addition to a universal concern about the safety of loved ones, many situations that emerged from the pandemic served as triggers for posttraumatic stress disorder symptoms for the veterans including hypervigilance, nightmares, and feelings of isolation (Grossman 2007). The triggers were exacerbated in the beginning by limited information about how the virus spread, how it would impact supply chains, and whether the city as an epicenter would be shut down with no residents able to leave. Many felt “on guard” against an “unseen threat” due to the virus being highly transmissible, invisible, and pervasive. One veteran reported a return of combat-related nightmares in which she shoots at targets that vanish before they are hit. After a rumor about bridges and tunnels potentially being shut down, another veteran woke up in the middle of the night panicking as if he were in a night raid on deployment. He urged his girlfriend to help him pack, and they left the city first thing the next morning.

During the height of the pandemic, emergency vehicle sirens were incessant. While it might be assumed that these sirens are triggers for veterans, most veterans I have worked with over the years say that helicopters are more of a trigger than sirens. At the beginning of the pandemic, helicopters were suddenly ubiquitous, whether for emergency response or monitoring stay-at-home and physical distancing orders, and many veterans commented on how disturbing the sound was. Another common trigger for the combat veterans I work with is fireworks. At every “fireworks holiday,” including Memorial Day and the Fourth of July, the veterans who are triggered by them establish a plan to be somewhere they cannot hear the blasts. In late July 2020, a rash of random firework detonations occurred throughout the city, further triggering posttraumatic stress symptoms for some veterans.

Stay-at-home orders also resulted in the sidewalks of New York being depopulated. Data estimates that 400,000 New Yorkers, approximately 5% of residents, left the city in the first 2 months of stay-at-home orders (Quealy 2020). In Jane Jacobs’ (1961) seminal work *The Death and Life of Great American Cities*, she outlines how cities are made lively and safe by the sidewalks being utilized at all times of the day and night with people patronizing stores, shops, parks, offices, and schools. The
resulting “eyes on the street” foster a sense of communal responsibility and identity cohesion (Jacobs 1961). Almost overnight the physical environment of New York shifted as it became vacant. Veterans started making direct comparisons to night patrols during deployment, with accompanying hypervigilance and other protective instincts kicking in. One veteran expressed surprise at how quickly it felt natural to sleep with weapons again. The hypervigilance was compounded for the veterans living with significant others who they knew were not as trained in assessing for danger. In one session with a veteran, we processed a major disagreement that resulted from him wanting to take a longer route home one night after not feeling safe on a street, with his wife flaunting his concern. He said, “She doesn’t understand, she acts like I’m paranoid but this situation is different. I know how to spot danger and she wants to think the city is the same.”

A Loss of Adaptive Coping Skills and a Return to Maladaptive Skills

One of the most difficult consequences of the pandemic is people’s loss of the social and recreational outlets that they engaged in for exercise, entertainment, and camaraderie. Many veteran support groups have an activity component, catering to a common veteran characteristic of enjoying being active and outdoors (Russell and Figley 2013). During the pandemic, many of these outlets closed, including gyms and fitness facilities that many of the veterans went to together. In-person support groups for mental health and substance abuse concerns also had to move to the virtual sphere. The increase in isolation was ideal for more introverted veterans, while it was a detriment to extroverted veterans and veterans trying to build their social networks and socialization skills. Developing plans for activity and physically spaced socialization within the significant stay-at-home restrictions became a key component of early sessions.

Many veterans appreciate the structure that the military offered and mimic this routine in their post-military occupations and activities. A switch to working from home or job loss led to some veterans struggling with changes to routines that had been regulating. With a move to telehealth for therapy sessions, some veterans became more consistent in attending sessions and more active in their verbal processing, while others struggled with not having the routine of coming to my office and meeting in person. For some veterans, their weekly session was one of their only outings from their apartment, and they utilized this to take steps toward being less isolated. With virtually attending their session without leaving home, the isolation persists.

It is estimated that more than 20% of veterans struggle with a substance use disorder (“PTSD and substance abuse in veterans,” n.d.-b). Since twelve-step and most intensive outpatient substance abuse programs are group therapy and peer support-based, the elimination of large gatherings caused some veterans to struggle with
getting support, especially if they did not feel connected in the virtual meeting rooms. Limited social and recreational options and an increase in physical isolation led some veterans to revert to coping with drugs and alcohol. The longer the pandemic stretches on, the harder it becomes for some veterans. One veteran with 10 years of sobriety had his first alcohol use cravings in years after building up a significant sober social life: “It feels like when I got back from deployment and would drink and just sit alone at home. I feel like I did this to myself, I know that I didn’t, but I’m just at home all day like I used to be when I drank, and so it makes me want to drink.”

**Survivor Guilt**

While not recognized as a stand-alone diagnosis by the *Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th Edition* (American Psychiatric Association 2013), survivor guilt is defined by the American Psychiatric Association (“Survivor guilt.”, n.d.) as, “remorse or guilt for having survived a catastrophic event when others did not or for not suffering the ills that others had to endure.” The phenomenon has been studied in veterans since the World War II (Menninger 1948) and is noted among survivors of other disasters and deadly illnesses. In my practice, I learn from my veterans to look more specifically for signs of survivor guilt, as they are easily mistaken for posttraumatic stress disorder or overlooked altogether due to the nature of the phenomenon, being that the veteran does not recognize the guilt as outsized or illogical. It was not a surprise when one veteran for whom survivor guilt is a primary focus in therapy started feeling anxiety about not being able to “fight this fight,” as it was up to the medical personnel and essential workers. Moreover, the veteran struggled with his identity as a healthy young man at low risk for sickness and death, while the streets filled every few minutes with the wail of ambulance sirens. During the height of the pandemic, our sessions were punctuated on both his and my end with these acute reminders of the crisis, and he would whisper with a shake of his head, “There’s another one.” Existential frustration also set in when some of the client’s friends and family reported they were not following stay-at-home and other safety guidelines, filling the client with simultaneous survivor guilt and helplessness at not being able to convince loved ones to take recommended precautions.

Some of the potential results of military service and posttraumatic growth include deep loyalty to a group and mission, as well as pride in taking part in history-making (Russell and Figley 2013). Almost immediately in our sessions, the veterans identified having a common bond with everyone in New York as we navigated being the global epicenter of the pandemic. This extended to the therapeutic alliance, breaking the invisible hierarchy of clinician-client into two equal residents of New York, a concept explored further in the “Clinician Self-Disclosure” section. Additionally, many of the veterans either joined the military as a response to the September 11th terrorist attacks or were living in or involved in the response to
Hurricane Sandy, creating protective roots to the city. This camaraderie with the city of New York and its residents might contribute to a sense of place attachment (Manzo and Perkins 2006). On the one hand, this ability to quickly feel allegiance with strangers allows veterans to effectively harness the power of coming together as a community. On the other hand, it can possibly trigger feelings of survivor guilt if the veteran left the city during the pandemic for safety, to be with friends and family, due to sudden economic changes or other logical reasons. Veterans with a predisposition for survivor guilt are particularly at risk.

For one veteran client who left the city only to come back a few weeks later, place attachment and its contribution to a sense of survivor guilt echoed in his statement that, “I just feel like I should be there, going through what everyone else is going through. How can I say I’m a New Yorker if I’m not there during this, even though I know I can’t help much?” While he was away, his survivor guilt first revealed itself through an increase in questions about “How is the city doing?” and asking for more personal anecdotes from my day-to-day life. I had the sense that the personal questions were not about me as his therapist but about me as a fellow New Yorker. At one point his survivor guilt started to taint our therapeutic relationship as he saw me as someone going through the collective trauma with the city, while he had left: “I’m sorry to keep telling you about my stress when I’m out in the countryside and you’re in the heart of it.” Even his use of the word “heart” instead of an objective locator is revealing about his connection to the city and its people. His survivor guilt became problematic because he returned to the city to soothe the guilt, but his return exacerbated the issue of his isolation because many of his friends had left the city or were not close by.

Moral Injury

Another deep emotional burden some veterans return from service with is moral injury. The US Department of Veterans Affairs (VA) defines moral injury as when people “perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations” (“Moral injury,” n.d.-a). This can result in long-standing feelings of guilt, shame, disgust, anger, and betrayal and can lead to self-sabotaging behaviors and a diminishing of spirituality (“Moral injury,” n.d.-a). Moral injuries include individual, amoral acts. However, in my experience, the combat veterans from the Iraq and Afghanistan wars often struggle with macro-level moral injuries in terms of what the American Idea represents. Perhaps this is because these wars are ongoing and therefore the question of what their service “was ultimately for” remains unanswered. The gap is filled by the nebulous notion that they upheld the American Idea around the world. Changes in politics and policy that shift the perception of America domestically and internationally can cause ethical dissonance for veterans and threaten how they emotionally and spiritually hold their service and the sacrifice of comrades who gave their life in defense of the American Idea.
During the early months of the pandemic, many of the veterans were troubled by perceived lack of moral authority in the response to the pandemic, on macro, mezzo, and micro levels. Some veterans found fault with federal, state, city, and military leadership, coordination, and initiatives. As the United States’ response to the pandemic evolved and was compared to the responses of other countries, some veterans were distressed by a perceived relinquishing of moral authority. Some veterans became more bewildered when some friends, family, and fellow Americans throughout the country pushed back on restrictions mandated and suggested to protect health. As one veteran put it, “We would go into combat wearing the American flag, knowing it might be the last thing we wore. I took pride in the work we did with our allies, with the leadership the flag conveyed. I went into battle so my countrymen wouldn’t have to, and in return people can’t wear a mask? Who are we now? What even is the American Idea? Is this experiment of democracy just not going to work out? What was my service for after all?” At the same time, other veterans viewed individuals’ choices as exercising the American freedom they fought to defend.

Clinician Self-Disclosure in the Context of Shared Trauma

One of the most significant shifts in our therapeutic alliances involved role reversals and clinical self-disclosure. Much has been written, particularly after 9/11, about shared traumas between clients and clinicians when they both experience the same natural or man-made disaster. The research suggests that shared trauma can lead to “blurring of clinician-client roles, increased clinician self-disclosure and emphasis on the shared nature of the experience” (Tosone 2011, p. 25). I experienced all three of these to varying degrees during the pandemic.

The blurring of clinician-client roles happened during the first sentence of my first telehealth call with a veteran. I did not even have time to say a salutation before the veteran declared, “Are you okay?” The parting salutation of that call was equally urgent, “Please stay safe.” Variations of these phrases still bookend most sessions with clients as the pandemic continues. The clients also started asking about my family. Usually I would maintain clinical boundaries by inquiring why it is helpful to know about the well-being of my family, but in a shared trauma it seemed clear that this was a more objective question, and it felt more than usual that it would cause a therapeutic rupture to decline to answer. I came up with a response I felt allowed me to answer their questions, assuage their fears, and join in the shared experience while also maintaining self-disclosure boundaries: “I am fortunate that all of my loved ones are healthy and safe, thank you.” Unfortunately, as some friends and family became ill and passed away, it was harder not only to modify this response truthfully but also to be reminded at the beginning of the session about my escalating personal struggles. As with non-veteran clients, the sessions were laced with more mutual sharing of firsthand reports of what was happening in different parts of the city, since stay-at-home orders prevented usually mobile New Yorkers from understanding what was happening even a few blocks away. Aside from merely
being self-disclosing, this was an effort by both parties to gather information that might be important for personal decision-making. As the de facto expert in the room on emotional safety, it was an interesting role reversal to be collaborating with the client on the uncertain basics of physical safety.

While I experienced this same pattern with non-veteran clients, the veteran clients were much more likely to engage with me in role reversal in a bid to preserve my safety. As aforementioned, part of the issue with New York being one of the first epicenters of the virus outbreak is that information about virus spread, supply chain impacts, and social consequences was minimal. Early sessions with veterans were filled with updates on information that they had received from friends and colleagues involved in the response, as well as predictions of what might happen and what action should be taken. At times, whether directly or indirectly, my clients suggested ways for me to stay safe, either by staying at home or leaving the city. The veteran who left the city after awakening in the middle of the night in a panic was so insistent that I leave the city that it was upsetting to him when he could see on the video telehealth system that I was still in my same living room. For the first time in my clinical career, I was navigating how to explain what sources of information I trust and personal circumstances within which I was making potentially life-and-death decisions while maintaining appropriate clinical boundaries. While my veteran clients are always respectful of my decisions, it was clear that the roles of crisis manager were reversed when the crisis was now logistical instead of emotional.

A key difference between the pandemic and other disasters is how long it is continuing. With most natural and man-made disasters, the acute danger has passed in a matter of hours, days, or weeks. By contrast, the pandemic continues as this chapter is written, nearly 5 months after the first stay-at-home orders were issued in New York. Clients continue to express concern for my well-being and end sessions with wishes for continued good health. Even though it took certain sections of the city months to return to normal after Hurricane Sandy, my clients only expressed similar worry for my well-being the first week or two because the storm had, literally, passed. As one client explained it recently, “The hurricane is still sitting over us.”

Organizational Pressures

Even at the beginning of the pandemic it was clear that resulting economic strife would take its toll on donations to nonprofit organizations. Veterans’ organizations are not immune to this. Some independent veteran organizations were set up to specifically fill support gaps in the VA, in particular allowing for more frequent and longer treatment sessions than the VA can support. Organizations facing funding cuts might have had to curtail treatment services in order to meet new budgetary restraints. Moreover, potential widespread mental health concerns triggered by the pandemic could lead to an increase in demand in the mental health sector. While an
accompanying increase in funding and support for mental health organizations is imperative, it could further deplete financial resources traditionally provided to veterans.

Conclusion

The COVID-19 pandemic presents challenges and opportunities when working with veterans, igniting preexisting triggers while tapping into reservoirs of posttraumatic growth. In particular, the virus threatening loved ones at home can spur posttraumatic stress symptoms including hypervigilance and anxiety. Some veterans have reverted to maladaptive coping mechanisms such as isolating and substance abuse. Other less recognized emotional wounds that veterans carry are also being reinforced, including survivor guilt. Dishearteningly, as behavioral and ethical decisions are made by Americans on micro, mezzo, and macro levels, some veterans experience a doubling down on moral injury, calling into question what America stands for in the world and what is the ultimate meaning of their service and the sacrifice of peers they lost. At the same time, veterans have been heartened by communities coming together and the courage of everyday Americans, whose lives they fought to protect, fighting to save the lives of others. The pandemic provides an opportunity for veterans to showcase their significant crisis management skills to the benefit of loved ones, their neighborhoods, and country. Finally, unexpectedly navigating a long-term shared trauma has shifted but ultimately strengthened our therapeutic alliances, allowing for the facets of our humanity only emergent in a crisis to adaptively connect.

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