

III. The Returning Veteran of the Iraq War: Background Issues and Assessment Guidelines

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It is safe to assume that all soldiers are impacted by their experiences in war. For many, surviving the challenges of war can be rewarding, maturing, and growth-promoting (e.g., greater self-efficacy, enhanced identity and sense of purposefulness, pride, camaraderie, etc.). The demands, stressors, and conflicts of participation in war can also be traumatizing, spiritually and morally devastating, and transformative in potentially damaging ways, the impact of which can be manifest across the lifespan.

This section of the *Iraq War Clinician Guide* provides information that is useful for addressing the following questions:

What are the features of the Iraq War that may significantly impact the quality of life, well-being, and mental health of returning veterans?

What are important areas of functioning to evaluate in returning veterans?

What might be beneficial for veterans of the Iraq War who request clinical services?

The material below provides an initial schematic so that clinicians in the Department of Veterans Affairs (VA) can begin to appreciate the experience of soldiers returning from the Iraq War. It is offered as a starting place rather than a definitive roadmap. Needless to say, each veteran will have a highly individualized and personal account of what happened, to them and what he or she experienced or witnessed, in Operation Iraqi Freedom. Each veteran will also reveal a unique set of social, psychological, and psychiatric issues and problems. At the end of the day, the most important initial needs of returning veterans are to be heard, understood, validated, and comforted in a way that matches their personal style. Every war is unique in ways that cannot be anticipated. There is much to be learned by listening carefully and intently.

The Form and Course of Adaptation to War-Zone Stressors

The psychological, social, and psychiatric toll of war can be immediate, acute, and chronic. These time intervals reflect periods of adaptation to severe war-zone stressors that are framed by different individual, contextual, and cultural features (and unique additional demands), which are important to appreciate whenever a veteran of war presents clinically.

The immediate interval refers to psychological reactions and functional impairment that occur in the war-zone during battle or while exposed to other severe stressors during the war. The immediate response to severe stressors in the war-zone has had many different labels over many centuries (e.g., combat fatigue); the label *combat stress reaction* is used most often currently. However, this is somewhat a misnomer. As we discuss below, direct combat exposure is not the only source of severe stress in a war-zone such as Iraq. The term *war-zone stress reaction* carries more meaning and is less stigmatizing to soldiers who have difficulties as a result of experiences

other than direct life-threat from combat. Generally, we also want to underscore to clinicians that being fired upon is only one of the many different severe stressors of the war-zone.

In the war-zone, soldiers are taxed physically and emotionally in ways that are unprecedented for them. Although soldiers are trained and prepared through physical conditioning, practice, and various methods of building crucial unit cohesion and buddy-based support, inevitably, war-zone experiences create demands and tax soldiers and unit morale in shocking ways. In addition, the pure physical demands of war-zone activities should not be underestimated, especially the behavioral and emotional effects of circulating norepinephrine, epinephrine and cortisol (stress hormones), which sustain the body's alarm reaction (jitteriness, hypervigilance, sleep disruption, appetite suppression, etc.). In battle, soldiers are taxed purposely so that they can retain their fighting edge. In addition, alertness, hypervigilance, narrowed attention span, and so forth, are features that have obvious survival value. Enlisted soldiers, non-commissioned officers, and officers are trained to identify the signs of normal "battle fatigue" as well as the signs of severe war-zone stress reactions that may incapacitate military personnel. However, the boundary line between "normal" and "pathological" response to the extreme demands of battle is fuzzy at best.

Officers routinely use post-battle "debriefing" to allow soldiers to vent and share their emotional reactions. The theory is that this will enhance morale and cohesion and reduce "battle fatigue." Even if soldiers manifest clear and unequivocal signs of severe war-zone stress reactions that affect their capacity to carry out their responsibilities, attempts are made to restore the soldier to duty as quickly as possible by providing rest, nourishment, and opportunities to share their experiences, as close to their units as possible. The guiding principal is known as Proximity - Immediacy - Expectancy - Simplicity ("PIES"). Early intervention is provided close to a soldier's unit, as soon as possible. Soldiers are told that their experience is normal and they can expect to return to their unit shortly. They are also provided simple interventions to counteract "fatigue" (e.g., "three hots and a cot"). The point here is that soldiers who experience severe war-zone stress reactions likely will have received some sort of special care. On the other hand, it is without question stigmatizing for soldiers to share fear and doubt and to reveal signs of reduced capacity. This is especially true in the modern, all volunteer, military with many soldiers looking to advance their careers. Thus, it is entirely possible that some veterans who present at VA Medical Centers will have suffered silently and may still feel a great need not to show vulnerability because of shame.

It should be noted that a very small percentage of soldiers actually become what are known as *combat fatigue casualties*. Research on Israeli soldiers has revealed that severe war-zone stress reactions are characterized by variability between soldiers and lability of presentation within soldiers. The formal features of severe incapacitating war-zone stress reactions are restlessness, psychomotor deficiencies, withdrawal, increased sympathetic nervous system activity, stuttering, confusion, nausea, vomiting, and severe suspiciousness and distrust. However, because soldiers will vary considerably in the form and course of their decompensation as a result of exposure to extreme stress, military personnel are prone to use a functional definition of combat fatigue casualty. For commanders, the defining feature is that the soldier ceases to function militarily as a combatant, and acts in a manner that endangers himself or herself and his or her fellow soldiers. If this kind of severe response occurs, soldiers may be evacuated from the battle area. Finally, clinicians should keep in mind that most combatants are young and that it is during the late teens and early twenties is a time when vulnerable individuals with family histories of psychopathology (or other diatheses) are at greatest risk for psychological decompensation prompted caused by the

stress of war. As a result, a very small number of veterans of the Iraq War may present with stress-induced severe mental illness.

For soldiers who may be in a war-zone for protracted periods of time, with ongoing risks and hazards, the acute adaptation interval spans the period from the point at which the soldier is objectively safe and free from exposure to severe stressors to approximately one month after return to the US, which corresponds to the one-month interval during which Acute Stress Disorder (ASD) may be diagnosed according to *DSM-IV*. This distinction is made so that a period of adaptation can be identified that allows clinicians to discern how a soldier is doing psychologically when they he or she gets a chance to recover naturally and receive rest and respite from severe stressors. Otherwise, diagnostic labels used to identify transient distress or impairment may be unnecessarily pathologizing and stigmatizing and inappropriate because they are confounded by ongoing exposure to war-zone demands and ongoing *immediate* stress reactions. Typically, in the acute phase, soldiers are in their garrison (in the US or overseas) or serving a security or infrastructure-building role after hostilities have ceased.

The symptoms of ASD include three dissociative symptoms (Cluster B), one reexperiencing symptom (Cluster C), marked avoidance (Cluster D), marked anxiety or increased arousal (Cluster E), and evidence of significant distress or impairment (Cluster F). The diagnosis of ASD requires that the individual has experienced at least three of the following: (a) a subjective sense of numbing or detachment, (b) reduced awareness of one's surroundings, (c) derealization, (d) depersonalization, or (e) dissociative amnesia. The disturbance must last for a minimum of two days and a maximum of four weeks (Cluster G), after which time a diagnosis of posttraumatic stress disorder (PTSD) should be considered (see below).

Research has shown that that there is little empirical justification for the requirement of three dissociation symptoms. Accordingly, experts in the field advocate for consistency between the diagnostic criteria for ASD and PTSD because many individuals fail to meet diagnostic criteria for ASD but ultimately meet criteria for PTSD despite the fact that their symptoms remain unchanged.

Unfortunately, there have been insufficient longitudinal studies of adaptation to severe war-zone stressors. On the other hand, there is a wealth of research on the temporal course of post-traumatic reactions in a variety of other traumatic contexts (e.g., sexual assault, motor vehicle accidents). These studies have revealed that the normative response to trauma is to experience a range of ASD symptoms initially with the majority of these reactions remitting in the following months. Generalizing from this literature, it is safe to assume that although acute stress reactions are very common after exposure to severe trauma in war, the majority of soldiers who initially display distress will naturally adapt and recover normal functioning during in the following months. Thus, it is particularly important not to not be unduly pathologizing about initial distress or even the presence of ASD.

The chronic phase of adjustment to war is well known to VA clinicians; it is the burden of war manifested across the life-span. It is important to note that psychosocial adaptation to war, over time, is not linear and continuous. For example, most soldiers are not debilitated in the immediate impact phase, but they are nevertheless at risk for chronic mental health problems implicated by experiences during battle. Also, although ASD is an excellent predictor of chronic PTSD, it is not a necessary precondition for chronic impairment - there is sufficient evidence to support the notion of delayed PTSD. Furthermore, the majority of people who develop PTSD did not meet the full diagnostic criteria for ASD beforehand. It is also important to appreciate that psychosocial and

psychiatric disturbance implicated by war-zone exposure waxes and wanes across the life-span (e.g., relative to life-demands, exposure to critical reminders of war experiences, etc.).

Posttraumatic stress disorder is one of many different ways a veteran can manifest chronic post-war adjustment difficulties. Veterans are also at risk for depression, substance abuse, aggressive behavior problems, and the spectrum of severe mental illnesses precipitated by the stress of war. Generally, the psychological risks from exposure to trauma are proportional to the magnitude or severity of exposure and the degree of life-threat *and perceived life-threat*. The latter is particularly pertinent to the war in Iraq, where the possibility of exposure to chemical or biological threats is a genuine concern. Exposure to chemical or biological toxins can be obscure, yet severely alarming before, during, and after battle.

A number of individual vulnerabilities have been shown to moderate risk for PTSD. For example, history of psychiatric problems (in particular, depression), poor coping resources or capacities, and past history of trauma and mistreatment increases risk for posttraumatic pathology. Individuals who show particularly intense and frequent symptoms of ASD (particularly, severe hyperarousal) in the weeks following trauma are particularly at risk for chronic PTSD. In addition, the quality and breadth of supports in both the military and civilian recovery contexts (in the military and outside the military) and beyond (e.g., in the home) can impact risk for PTSD. People who need intervention most are the ones that are isolated and cannot get the respite from work, family, and social demands that they may need (or who have additional family or financial stressors and burdens), have few secure and reliable outlets for unburdening their experiences, and receive little or no validation, in the weeks, months, and years following exposure to war trauma.

Most VA clinicians will interact with veterans of the new Iraq War during the chronic phase of adjustment. Nevertheless, early assessment of PTSD and other comorbid conditions implicated from exposure to the Iraq War is crucial and providing effective treatment as soon as possible is critical. Although technically chronic with respect to *time since hostilities ceased*, soldiers' mental health status will be relatively new with respect to their extra-war roles and social context. For example, a soldier might be newly reunited with family and friends, which may tax coping resources and produce shame and lead to withdrawal. In this context, interventions provided as early as possible will still provide secondary prevention of very chronic maladaptive behavior and adaptation.

On the other hand, it is important to appreciate that many things may have happened to a veteran with steady difficulties through the immediate and acute phases that color the person's clinical presentation. For example, a soldier may have been provided multiple interventions in the war-zone and in the acute phase, such as *critical incident stress debriefing* (CISD), or pastoral counseling, or formal psychiatric care. It is important to assess and appreciate the course of care provided and not to assume that the veteran is first now presenting with problems. It could be that some veterans experienced their attempts to get help and guidance or respite as personal failure and they may have been stigmatized, ostracized, or subtly punished for doing so.

What Kinds of War-Zone Stressors Did Soldiers in the Iraq War Confront?

It is important to appreciate the various types of demands, stressors, and potentially traumatizing events that veterans of the Iraq War may have experienced. This will serve to facilitate communication between clinician and patient and enhance understanding and empathy. Although

there may be one or two specific traumatic events burned into the consciousness of returning soldiers that plague them psychologically, traumatic events need to be seen in the context of the totality of roles and experiences in the war-zone. In addition, research has shown convincingly that while exposure to trauma is a prerequisite for the development of significantly impairing PTSD, it is necessary but not sufficient. For veterans, there are a host of causes of chronic PTSD. In terms of war-zone experiences, perceived threat, low-magnitude stressors, exposure to suffering civilians suffering, and exposure to death and destruction, have each been found to contribute to risk for chronic PTSD. It should also be emphasized that the trauma of war is colored by a variety of emotional experiences, not just horror, terror, and fear. Candidate emotions are sadness about losses, or frustration about bearing witnessing to suffering, guilt about personal actions or inactions, and anger or rage about any number facets of the war (e.g., command decisions, the behavior of the enemy).

We describe below the types of stressful war-zone experiences that veterans of the first Persian Gulf War reported as well as the psychological issues and problems that may arise as a result. We assume that many of these categories or themes will apply to returnees from the War with Iraq.

Preparedness. Some veterans may report anger about perceiving that they were not sufficiently prepared or trained for what they experienced in the war. They may believe that they did not have equipment and supplies they needed or that they were insufficiently trained to perform necessary procedures and tasks using equipment and supplies. Some soldiers may feel that they were ill prepared for what to expect in terms of their role in the deployment and what it would be like in the region (e.g., the desert). Some veterans may have felt that they did not sufficiently know what to do in case of a nuclear, biological, or chemical attack. Clinically, veterans who report feeling angry about these issues may have felt relatively more *helplessness* and *unpredictability* in the war-zone, factors which that have been shown to increase risk for PTSD.

Combat exposure. It appears that the new Iraq War entails more stereotypical exposure to warfare experiences such as firing a weapon, being fired on (by enemy or potential friendly fire), witnessing injury and death, and going on special missions and patrols that involve such experiences, than the ground war offensive of the Persian Gulf War, which lasted three days. Clinicians who have extensive experience treating veterans of other wars, particularly Vietnam, Korea, and WWII should be aware of the bias this may bring to bear when evaluating the significance or impact of experiences in modern warfare. Namely, clinicians need to be careful not to minimize reports of light or minimal exposure to combat. They should bear in mind that in civilian life, for example, a person could suffer from chronic PTSD as a result of a single, isolated life-threat experience (such as a physical assault or motor vehicle accident).

Aftermath of battle. Veterans of the new Iraq War will no doubt report exposure to the consequences of combat, including observing or handling the remains of civilians, enemy soldiers, US and allied personnel, or animals, dealing with prisoners of war, and observing other consequences of combat such as devastated communities and homeless refugees. Veterans may have been involved in removing dead bodies after battle. They may have seen homes or villages destroyed or they may have been exposed to the sight, sound, or smell of dying men and women. These experiences may be intensely demoralizing for some. It also is likely that memories of the aftermath of war (e.g., civilians dead or suffering) are particularly disturbing and salient.

Perceived threat. Veterans may report acute terror and panic and sustained anticipatory anxiety about *potential exposure* to circumstances of combat, including nuclear (e.g., via the use of

depleted uranium in certain bombs), biological, or chemical agents, missiles (e.g., SCUD attacks), and friendly fire incidents. Research has shown that perceptions of life-threat are powerful predictors of post-war mental health outcomes.

Difficult living and working environment. These low-magnitude stressors are events or circumstances representing repeated or day-to-day irritations and pressures related to life in the war zone. These personal discomforts or deprivations may include the lack of desirable food, lack of privacy, poor living arrangements, uncomfortable climate, cultural difficulties, boredom, inadequate equipment, and long workdays. These conditions are obviously non-traumatizing but they tax available coping resources, which may contribute to post-traumatic outcomes.

Concerns about life and family disruptions. Soldiers may worry or ruminate about how their deployment might negatively affect other important life-domains. For National Guard and Reserve troops, this might include career-related concerns (e.g., losing a job or missing out on a promotion). For all soldiers, there may be family-related concerns (e.g., damaging relationships with spouse or children or missing significant events such as birthdays, weddings, and deaths). The replacement of the draft with an all-volunteer military force and the broadening inclusion of women in a wide variety of positions (increasing their potential exposure to combat) significantly change the face of this new generation of veterans. Single parent and dual-career couples are increasingly common in the military, which highlights the importance developing a strong working relationship between the clinician, the veteran and his or her family. As is the case with difficult living and working conditions, concerns about life and family disruptions can tax coping resources and affect performance in the war-zone.

Sexual or gender harassment. Some soldiers may experience unwanted sexual touching or verbal conduct of a sexual nature from other unit members, commanding officers, or civilians in the war zone that creates a hostile working environment. Alternatively, exposure to harassment that is non-sexual may occur on the basis of gender, minority, or other social status. This kind of harassment may be used to enforce traditional roles, or in response to the violation of these roles. Categories of harassment include indirect resistance to authority, deliberate sabotage, indirect threats, constant scrutiny, and gossip and rumors directed toward individuals. In peacetime, these types of experiences are devastating for victims and create helplessness, powerlessness, rage, and great stress. In the war-zone, they are of no less impact.

Ethnocultural stressors. Minority soldiers may in some cases be subject to various stressors related to their ethnicity (e.g., racist remarks). Some service members who may appear to be of Arab background may experience added racial prejudice/stigmatization, such as threatening comments or accusations directed to their similarity in appearance to the enemy. Also, some Americans actually of Arab descent may experience conflict between their American identity and identity related to their heritage. Such individuals may have encountered pejorative statements about Arabs and Islam as well as devaluation of the significance of loss of life among the enemy.

Perceived radiological, biological, and chemical weapons exposure. Some veterans of the Iraq War will report personal exposures to an array of radiological, nuclear, biological, and chemical agents that the veteran believes he/she encountered while serving in the war-zone. Given the extensive general knowledge of Persian Gulf War Illnesses among soldiers (and the public), there is no doubt that veterans of the new Iraq War will experience concerns about potential unknown low-level exposure that may affect their health chronically. For some, these perceptions may

produce a hypervigilant internal focus of attention on subtle bodily reactions and sensations, which may lead to a variety of somatic complaints.

Assessment

New veterans of the war with Iraq will present initially in a myriad of different ways. Some may be very frail, labile, emotional, and needing to share their story. The modal presentation is likely to be defended, formal, respectful, laconic, and cautious (as if they were talking to an officer). Generally, it is safe to assume that it will be difficult for new veterans of the Iraq War to share their thoughts and feelings about what happened during the war and the toll those experiences have taken on their mental health. It is important not to press any survivor of trauma too soon or too intensely and respect the person's need not to feel vulnerable and exposed. Clinical contacts should proceed from triage (e.g., suicidality/homicidality, acute medical problems, and severe family problems may require *immediate* attention), screening, formal assessment, to case formulation / treatment planning, with an emphasis on prioritizing targets for intervention. In all contacts, the clinician should meet the veteran where he or she is with respect to immediate needs, communication style, and emotional state. Also, the clinician should provide the veteran a plan for how the interactions may proceed over time and how they might be useful. The goal in each interaction is to make sure the veteran feels heard, understood, respected, and cared for.

Comprehensive assessment will inform case formulation and treatment planning. There are many potentially important variables to assess when working with a veteran of the Iraq War:

- Work functioning
- Interpersonal functioning
- Recreation and self-care
- Physical functioning
- Psychological symptoms
- Past distress and coping
- Previous traumatic events
- Deployment-related experiences

Often, when working with individuals who have been exposed to potentially traumatic experiences, there is pressure to begin with an assessment of traumatic exposure and to encourage the veteran to immediately talk about his or her experiences. However, our recommendation is that it is most useful to begin the assessment process by focusing on current psychosocial functioning and the immediate needs of the veteran and to assess trauma exposure, as necessary, later in the assessment process. While we discuss assessment of trauma history more fully below, it is important to note here that the best rule of thumb is to follow the patient's lead in approaching a discussion of trauma exposure. Clinicians should verbally and non-verbally convey to their patients a sense of safety, security and openness to hearing about painful experiences. However, it is also equally important that clinicians do not urge their patients to talk about traumatic experiences before they are ready to do so.

Work functioning. Work-related difficulties can have a significant impact on self-efficacy, self-worth and financial stability and thus deserve immediate attention, assessment, and referral. They are likely to be a major focus among veterans of the Iraq War. Part-time military employees or reservists (who make up a significant proportion of the military presence in Iraq) face unique employment challenges post-deployment. Employers vary significantly in the amount of emotional and financial support they offer their reservist employees. Some veterans will inevitably have to confront the advancement of their co-workers while their own civilian career has stalled during their military service. While some supportive employers supplement reservist's reduced military

salaries for longer than required, the majority does not, leaving many returning soldiers in dire financial situations.

Employment issues can be a factor even among reservists who work for supportive employers. Often, the challenges inherent in military duty can impact a soldier's satisfaction with his or her civilian position. Thus, some returning veterans may benefit from a re-assessment of vocational interest and aptitude.

Clinicians will also encounter veterans who have voluntarily and/or involuntarily ended their military service following their deployment to Iraq. Issues related to this separation may include the full-range of emotional responses including relief, anger, sadness, confusion and despair. Veterans in this position might benefit from employment related assessment and rehabilitation services including an exploration of career interests and aptitudes, counseling in resume building and job interviewing, vocational retraining, and emotional processing of psychological difficulties impeding work success and satisfaction.

Interpersonal functioning. Another important area of assessment involves interpersonal functioning. Veterans of the Iraq war hold a number of interpersonal roles including son/daughter, husband/wife/partner, parent, and friend and all of these roles may be affected by the psychological consequences of their military service. A number of factors can affect interpersonal functioning including the quality of the relationship pre-deployment, the level of contact between the veteran and his or her social network during deployment, and the expectations and reality of the homecoming experience.

The military offers some support mechanisms for the families of soldiers, which are aimed at shoring up these supportive relationships and smoothing the soldier's readjustment upon return from Iraq. It can be useful to assess the extent to which a veteran and his or her family has used these services and how much they did or did not benefit from such services. It is important to note that these services do not always extend to non-married partners (of the same or different gender), sometimes leading to a more difficult and challenging homecoming experience.

As with all areas of post-deployment adjustment, veterans may experience changes in their interpersonal functioning over time. It is not uncommon for families to first experience a "honeymoon" phase of reconnection marked by euphoria, excitement, and relief. However, a period of discomfort, role confusion, and renegotiating of relationship and roles can follow this initial phase. Thus, repeated assessment of interpersonal functioning over time can ensure that any relational difficulties that threaten the well-being of the veteran are detected and addressed.

Depending on specific personal characteristics of the veteran, certain interpersonal challenges may be more or less relevant to assessment and treatment. For instance, younger veterans, particularly those who live with their family of origin, may have a particularly difficult time returning to their role as adult children. The process of serving active duty in a war-zone is a maturing one, and younger veterans may feel as if they have made a significant transition to adulthood that may conflict with parental expectations and demands over time.

Veterans who are parents may feel somewhat displaced by the caretaker who played a primary role in their child's life during deployment. Depending on their age, the children of veterans may exhibit a wide range of regressive and/or challenging behaviors that may surprise and tax their returning parent. This normal, expected adjustment can become problematic and prolonged if the

veteran is struggling with his or her own psychological distress post-deployment. Thus, early (and repeated) assessment and early family oriented intervention may be indicated.

Finally, homecoming and subsequent interpersonal functioning can be compounded if the veteran was physically wounded during deployment. Younger families may be particularly less prepared to deal with the added stress of recovery, rehabilitation and/or adjustment to a chronic physical disability.

Recreation and self-care. Participation in recreational activities and engaging in good self-care are foundational aspects of positive psychological functioning. However, they are often overlooked in the assessment process. Some veterans who appear to be functioning well in other domains may be attending less to these areas of their lives, particularly if they are attempting to appear “stoic” and to keep busy in order to control any painful thoughts, feelings or images they may be struggling with. Thus, a brief assessment of engagement in and enjoyment of recreational and self-care activities may provide some important information about how well the veteran is coping post-deployment.

Physical functioning. Early assessment of the physical well being of veterans is critical. Sleep, appetite, energy level, and concentration can be impaired in the post-deployment phase as a result of exposure to potentially traumatizing experiences, the development of any of a number of physical disease processes and/or the sheer fatigue associated with military duty. Clinicians are again charged with the complex task of balancing the normalization of transient symptoms with the careful assessment of symptoms that could indicate more significant psychological or physical impairment. Consistent with good clinical practices, it is important to ensure that a veteran complaining of these and other somatic/psychological symptoms be referred for a complete physical examination to investigate any potential underlying physical pathology and to provide adequate interdisciplinary treatment planning.

Psychological symptoms. Once the clinician gains an overall sense of the veteran’s level of psychosocial functioning, a broader assessment of psychological symptoms, and responses to those symptoms that may be impairing can be useful. However, this process can also be difficult and confusing since a wide range of emotional and cognitive responses to deployment and post-deployment stressors including increased fear and anxiety, sadness and grief, anger or rage, guilt, shame and disgust, ruminations and intrusive thoughts about past experiences, and worries and fears about future functioning may be expected. Often a good clinical interview can elicit some information about the most salient symptoms for a particular veteran, which can be supplemented with more structured assessment using diagnostic interviews and/or questionnaires.

Again, clinicians must use their judgment in responding to transient normal responses to potentially traumatizing events versus symptoms that may reflect the development and/or exacerbation of a psychological disorder. Sometimes assessing both psychological responses and responses to those responses can help determine whether or not some form of treatment is indicated. For instance, veterans may appropriately respond to the presence of painful thoughts and feelings by crying, talking with others about their experiences, and engaging in other potentially valued activities such as spending time with friends and family. However, others may attempt to suppress, diminish or avoid their internal experiences of pain by using alcohol and/or drugs, disordered eating, self-injurious behaviors (such as cutting), dissociation and behavioral avoidance of external reminders or triggers of trauma-related stimuli.

Given that a full-range of psychological responses may be seen, and given that multiple symptoms (and comorbid disorders) may be present, one challenge to the clinician during the assessment process is to prioritize targets of potential treatment. A few general rules of thumb can be helpful:

- First, one must immediately attend to symptoms that may require emergency intervention such as significant suicidal or homicidal ideation, hopelessness, self-injurious behavior and/or acute psychotic symptoms.
- Second, it is useful to address symptoms that are most disruptive to the veteran (which should be evidenced by a careful assessment of psychosocial functioning).
- Finally, the best way to develop a treatment plan for a veteran with diverse complaints is to develop a case formulation to functionally explain the potential relationship between the symptoms in order to develop a comprehensive treatment plan. Substance abuse, disordered eating, and avoidance of trauma-related cues may all represent attempts to avoid thoughts, feelings and images of trauma-related experiences. Thus, developing an intervention that focuses on avoidance behavior per se, rather than on specific and diverse symptoms of avoidance, may be a more effective treatment strategy.

Past distress and coping. In determining the extent of treatment needed for a particular presenting problem, an assessment of the history of the problem and the veteran's previous responses to similar stressful experiences is useful. A general sense of pre-deployment work and interpersonal functioning, along with any significant psychological history can place current distress in context. A diathesis-stress model suggests that veterans with a history of mental health difficulties can be at increased risk for psychological problems following a stressful event such as deployment to a war-zone, although this relationship is not absolute.

Another area worth assessing, that can provide a wealth of pertinent information, is the veteran's general orientation toward coping with difficult life events and its potential relationship to current painful thoughts, emotions and bodily sensations. Many veterans will enter into their military experience with a flexible and adaptive array of coping skills that they can easily bring to bear on their current symptoms. In other cases, veterans may have successfully used coping strategies in the past that are no longer useful in the face of the current magnitude of their symptoms. Coping styles can be assessed with one of a number of self-report measures. However, through a sensitive clinical interview, one can also get a general sense of how often the veteran generally uses common coping styles such as stoicism, social support, suppression and avoidance, and active problem solving.

Previous traumatic events. While there is evidence in the literature for a relationship between repeated lifetime exposure to traumatic events and compromised post-event functioning, this relationship may be less evident among veterans who are seen in the months following their return from Iraq. However, there may still be important clinical information to be gained from assessing a veteran's lifetime experience with such traumatic events such as childhood and adult sexual and physical abuse, domestic violence, involvement in motor vehicle or industrial accidents, and experience with natural disasters, as well as their immediate and long-term adjustment following those experiences.

Deployment-related experiences. Obviously, the assessment of potentially traumatizing events that occurred during deployment will be an important precursor to treatment for many veterans of the Iraq War, particularly for those who struggle with symptoms of reexperiencing, avoidance/

numbing, dissociation, and/or increased arousal. VA clinicians are highly skilled in many of the clinical subtleties involved in this assessment such as the importance of providing a safe and nonjudgmental environment, allowing the veteran to set the pace and tone of the assessment, and understanding the myriad of issues that involve the disclosure of traumatic experiences such as shame, guilt, confusion, and the need by some soldiers to appear resilient and unaffected by their experiences. However, unique deployment stressors accompany involvement in each contemporary military action that may be important to assess. Thus, clinicians need to balance their use of current exposure assessment methods with openness to hearing and learning from each new veterans personal experience.

Section 1 of the Deployment Risk and Resiliency Inventory, developed by Daniel and Lynda King and colleagues at the National Center for PTSD, can provide an excellent starting point for the assessment of deployment related stressors and buffers. Items on this measure were derived from focus groups with Persian Gulf veterans and they provide useful information about some of the newer stressors associated with contemporary deployments.

The inventory is provided in *Appendix D*. Section 1 describes 9 domains of war-zone stressors that Iraq veterans may have experienced: preparedness, combat exposure, aftermath of battle, perceived threat, difficult living and working environment, concerns about life and family disruptions, ethnocultural stressors, perceived radiological, biological and chemical weapons exposure. A careful assessment of each of these domains can be useful both as a starting point for assessing any potential ASD and/or PTSD and more generally to establish a sense of the potential risk and resiliency factors that may bear on the veteran's current and future functioning.

Summary and Final Remarks

Individuals join the military for a variety of reasons, from noble to mundane. Regardless, over time, soldiers develop a belief system (schema) about themselves, their role in the military, the military culture, etc. War can be traumatizing not only because of specific terrorizing or grotesque war-zone experiences but also due to dashed or painfully shattered expectations and beliefs about perceived coping capacities, military identity, and so forth. As a result, soldiers who present for care in VA Medical Centers may be disillusioned in one way or another. The clinician's job is to gain an appreciation of the veteran's prior schema about their role in the military (and society) and the trouble the person is having assimilating (incorporating) war-zone experiences into that existing belief system. Typically, in traumatized veterans, assimilation is impossible because of the contradictory nature of painful war-zone events. The resulting conflict is unsettling and disturbing. Any form of early intervention or treatment for chronic PTSD entails providing experiences and new knowledge so that accommodation of a new set of ideas about the self and the future can occur.

A variety of factors including personal and cultural characteristics, orientation toward coping with stressors and painful emotions, pre-deployment training, military-related experiences, and post-deployment environment will shape responses to the Iraq War. Further, psychological responses to deployment experiences can be expected to change over time. While mental health professionals within the VA are among the most experienced and accomplished in assessing and treating chronic combat-related PTSD, veterans of the Iraq war can be expected to present unique clinical challenges.

The absence of immediate symptoms following exposure to a traumatic event is not necessarily predictive of a long-term positive adjustment. Depending on a variety of factors, veterans may appear to be functioning at a reasonable level immediately upon their return home particularly given their relief at having survived the war-zone and returned to family and friends. However, as life circumstances change, symptoms of distress may increase to a level worthy of clinical intervention.

Even among those veterans who will need psychological services post-deployment, ASD and PTSD represent only two of a myriad of psychological presentations that are likely. Veterans of the Iraq war are likely to have been exposed to a wide variety of war-zone related stressors that can impact psychological functioning in a number of ways.

The psychological assessment of veterans returning from Iraq is likely to be complicated and clinically challenging. We must enter into the assessment process informed about the possible stressors and difficulties that may be associated with service in Iraq and open to suspending any preconceived notions about how any given individual might react to their personal experience during war. It will be important for us to broadly assess functioning over a variety of domains, to provide referrals for acute needs, and to provide some normalizing, psychoeducational information to veterans and their families in an attempt to facilitate existing support networks and naturally occurring healing processes. Repeated assessment over time will best serve our veterans who may experience changing needs over the months and years following their wartime exposure.

IV. Treatment of the Returning Iraq War Veteran

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In this section of the *Iraq War Clinician Guide*, we discuss treatment of veterans recently evacuated due to combat or war stress who are brought to the VA for mental health care, and Iraq War veterans seeking mental health care at VA medical centers and Vet Centers. This section complements discussion of special topics (e.g., treatment of medical casualties, identification and management of PTSD in the primary care setting, issues in caring for veterans who have been sexually assaulted, traumatic bereavement) that are addressed in other sections of this *Guide*.

It is important that VA and Vet Center clinicians recognize that the skills and experience that they have developed in working with veterans with chronic PTSD will serve them well with those returning from the Iraq War. Their experience in talking about trauma, educating patients and families about traumatic stress reactions, teaching skills of anxiety and anger management, facilitating mutual support among groups of veterans, and working with trauma-related guilt, will all be useful and applicable. Here, we highlight some challenges for clinicians, discuss ways in which care of these veterans may differ from our usual contexts of care, and direct attention to particular methods and materials that may be relevant to the care of the veteran recently traumatized in war.

The Helping Context: Active Duty vs. Veterans Seeking Health Care

There are a variety of differences between the contexts of care for active duty military personnel and veterans normally being served in VA that may affect the way practitioners go about their business. First, many Iraq War patients will not be seeking mental health treatment. Some will have been evacuated for mental health or medical reasons and brought to VA, perhaps reluctant to acknowledge their emotional distress and almost certainly reluctant to consider themselves as having a mental health disorder (e.g., PTSD). Second, emphasis on diagnosis as an organizing principle of mental health care is common in VA. Patients are given *DSM-IV* diagnoses, and diagnoses drive treatment. This approach may be contrasted with that of frontline psychiatry, in which pathologization of combat stress reactions is strenuously avoided. The strong assumption is that most soldiers will recover, and that their responses represent a severe reaction to the traumatic stress of war rather than a mental illness or disorder. According to this thinking, the “labeling” process may be counterproductive in the context of early care for Iraq War veterans. As Koshes (1996) noted, “labeling a person with an illness can reinforce the “sick” role and delay or prevent the soldier’s return to the unit or to a useful role in military or civilian life” (p. 401).

Patients themselves may have a number of incentives to minimize their distress: to hasten discharge, to accelerate a return to the family, to avoid compromising their military career or retirement. Fears about possible impact on career prospects are based in reality; indeed, some will be judged medically unfit to return to duty. Veterans may be concerned that a diagnosis of PTSD, or even Acute Stress Disorder, in their medical record may harm their chances of future promotion, lead to a decision to not be retained, or affect type of discharge received. Some may think that the information obtained if they receive mental health treatment will be shared with their unit commanders, as is sometimes the case in the military.

To avoid legitimate concerns about possible pathologization of common traumatic stress reactions, clinicians may wish to consider avoiding, where possible, the assignment of diagnostic labels such as ASD or PTSD, and instead focus on assessing and documenting symptoms and behaviors. Diagnoses of acute or adjustment disorders may apply if symptoms warrant labeling. Concerns about confidentiality must be acknowledged and steps taken to create the conditions in which patients will feel able to talk openly about their experiences, which may include difficulties with commanders, misgivings about military operations or policies, or possible moral concerns about having participated in the war. It will be helpful for clinicians to know who will be privy to information obtained in an assessment. The role of the assessment and who will have access to what information should be discussed with concerned patients.

Active duty service members may have the option to remain on active duty or to return to the war zone. Some evidence suggests that returning to work with one's cohort group during wartime can facilitate improvement of symptoms. Although their wishes may or may not be granted, service members often have strong feelings about wanting or not wanting to return to war. For recently activated National Guard and Reservists, issues may be somewhat different (Dunning, 1996). Many in this population never planned to go to war and so may be faced with obstacles to picking up the life they "left." Whether active duty, National Guard, or Reservist, listening to and acknowledging their concerns will help empower them and inform treatment planning.

Iraq War patients entering residential mental health care will have come to the VA through a process different from that experienced by "traditional" patients. If they have been evacuated from the war zone, they will have been rapidly moved through several levels of medical triage and treatment, and treated by a variety of health care providers (Scurfield & Tice, 1991). Many will have received some mental health care in the war zone (e.g., stress debriefing) that will have been judged unsuccessful. Some veterans will perceive their need for continuing care as a sign of personal failure. Understanding their path to the VA will help the building of a relationship and the design of care.

More generally, the returning soldier is in a state of transition from war zone to home, and clinicians must seek to understand the expectations and consequences of returning home for the veteran. Is the veteran returning to an established place in society, to an economically deprived community, to a supportive spouse or cohesive military unit, to a large impersonal city, to unemployment, to financial stress, to an American public thankful for his or her sacrifice? Whatever the circumstances, things are unlikely to be as they were:

The deployment of the family member creates a painful void within the family system that is eventually filled (or denied) so that life can go on...The family assumes that their experiences at home and the soldier's activities on the battlefield will be easily assimilated by each other at the time of reunion and that the pre-war roles will be resumed. The fact that new roles and responsibilities may not be given up quickly upon homecoming is not anticipated (Yerkes & Holloway, 1996, p. 31).

Learning from Vietnam Veterans with Chronic PTSD

From the perspective of work with Vietnam veterans whose lives have been greatly disrupted by their disorder, the chance to work with combat veterans soon after their war experiences represents a real opportunity to prevent the development of a disastrous life course. We have the

opportunity to directly focus on traumatic stress reactions and PTSD symptom reduction (e.g., by helping veterans process their traumatic experiences, by prescribing medications) and thereby reduce the degree to which PTSD, depression, alcohol/substance misuse, or other psychological problems interfere with quality of life. We also have the opportunity to intervene directly in key areas of life functioning, to reduce the harm associated with continuing post-traumatic stress symptoms and depression if those prove resistant to treatment. The latter may possibly be accomplished via interventions focused on actively supporting family functioning in order to minimize family problems, reducing social alienation and isolation, supporting workplace functioning, and preventing use of alcohol and drugs as self-medication (a different focus than addressing chronic alcohol or drug problems).

Prevent family breakdown. At time of return to civilian life, soldiers can face a variety of challenges in re-entering their families, and the contrast between the fantasies and realities of homecoming (Yerkes & Holloway, 1996) can be distressing. Families themselves have been stressed and experienced problems as a result of the deployment (Norwood, Fullerton, & Hagen, 1996; Jensen & Shaw, 1996). Partners have made role adjustments while the soldier was away, and these need to be renegotiated, especially given the possible irritability and tension of the veteran (Kirkland, 1995). The possibility exists that mental health providers can reduce long term family problems by helping veterans and their families anticipate and prepare for family challenges, involving families in treatment, providing skills training for patients (and where possible, their families) in family-relevant skills (e.g., communication, anger management, conflict resolution, parenting), providing short-term support for family members, and linking families together for mutual support.

Prevent social withdrawal and isolation. PTSD also interferes with social functioning. Here the challenge is to help the veteran avoid withdrawal from others by supporting re-entry into existing relationships with friends, work colleagues, and relatives, or where appropriate, assisting in development of new social relationships. The latter may be especially relevant with individuals who leave military service and transition back into civilian life. Social functioning should be routinely discussed with patients and made a target for intervention. Skills training focusing on the concrete management of specific difficult social situations may be very helpful. Also, as indicated below, clinicians should try to connect veterans with other veterans in order to facilitate the development of social networks.

Prevent problems with employment. Associated with chronic combat-related PTSD have been high rates of job turnover and general difficulty in maintaining employment, often attributed by veterans themselves to anger and irritability, difficulties with authority, PTSD symptoms, and substance abuse. Steady employment, however, is likely to be one predictor of better long term functioning, as it can reduce financial stresses, provide a source of meaningful activity and self-esteem, and give opportunities for companionship and friendship. In some cases, clinicians can provide valuable help by supporting the military or civilian work functioning of veterans, by teaching skills of maintaining or, in the case of those leaving the military, finding of employment, or facilitating job-related support groups.

Prevent alcohol and drug abuse. The comorbidity of PTSD with alcohol and drug problems in veterans is well established (Ruzek, 2003). Substance abuse adds to the problems caused by PTSD and interferes with key roles and relationships, impairs coping, and impairs entry into and ongoing participation in treatment. PTSD providers are aware of the need to routinely screen and assess for

alcohol and drug use, and are knowledgeable about alcohol and drug (especially 12-Step) treatment. Many are learning, as well, about the potential usefulness of integrated PTSD-substance abuse treatment, and the availability of manualized treatments for this dual disorder. “Seeking Safety,” a structured group protocol for trauma-relevant coping skills training (Najavits, 2002), is seeing increased use in VA and should be considered as a treatment option for Iraq War veterans who have substance use disorders along with problematic traumatic stress responses. In addition, for many newly returning Iraq War veterans, it will be important to supplement traditional abstinence-oriented treatments with attention to milder alcohol problems, and in particular to initiate preventive interventions to reduce drinking or prevent acceleration of alcohol consumption as a response to PTSD symptoms (Bien, Miller, & Tonigan, 1993). For *all* returning veterans, it will be useful to provide education about safe drinking practices and the relationship between traumatic stress reactions and substance abuse.

General Considerations in Care

Connect with the returning veteran. As with all mental health counseling, the relationship between veteran and helper will be the starting point for care. Forming a working alliance with some returnees may be challenging, however, because most newly-returned veterans may be, as Litz (this Guide) notes, “defended, formal, respectful, laconic, and cautious” and reluctant to work with the mental health professional. Especially in the context of recent exposure to war, validation (Kirkland, 1995) of the veteran’s experiences and concerns will be crucial. Discussion of “war zone”, not “combat,” stress may be warranted because some traumatic stressors (e.g., body handling, sexual assault) may not involve war fighting as such. Thought needs to be given to making the male-centric hospital system hospitable for women, especially for women who have experienced sexual assault in the war zone (see Special Topic VI, this Guide), for whom simply walking onto the grounds of a VA hospital with the ubiquitous presence of men may create feelings of vulnerability and anxiety.

Practitioners should work from a patient-centered perspective, and take care to find out the current concerns of the patient (e.g., fear of returning to the war zone, concerns about having been evacuated and what this means, worries about reactions of unit, fear of career ramifications, concern about reactions of family, concerns about returning to active duty). One advantage of such an orientation is that it will assist with the development of a helping relationship.

Connect veterans with each other. In treatment of chronic PTSD, veterans often report that perhaps their most valued experience was the opportunity to connect in friendship and support with other vets. This is unlikely to be different for returning Iraq War veterans, who may benefit greatly from connection both with each other and with veterans of other conflicts. Fortunately, this is a strength of VA and Vet Center clinicians, who routinely and skillfully bring veterans together.

Offer practical help with specific problems. Returning veterans are likely to feel overwhelmed with problems, related to workplace, family and friends, finances, physical health, and so on. These problems will be drawing much of their attention away from the tasks of therapy, and may create a climate of continuing stress that interferes with resolution of symptoms. The presence of continuing negative consequences of war deployment may help maintain post-traumatic stress reactions. Rather than treating these issues as distractions from the task at hand, clinicians can provide a valuable service by helping veterans identify, prioritize, and execute action steps to address their specific problems.

Attend to broad needs of the person. Wolfe, Keane, and Young (1996) put forward several suggestions for clinicians serving Persian Gulf War veterans that are also important in the context of the Iraq War. They recommended attention to the broad range of traumatic experience (e.g., as discussed in Chapter III). They similarly recommended broad clinical attention to the impact of both pre-military and post-military stressors on adjustment. For example, history of trauma places those exposed to trauma in the war zone at risk for development of PTSD, and in some cases war experiences will activate emotions experienced during earlier events. Finally, recognition and referral for assessment of the broad range of physical health concerns and complaints that may be reported by returning veterans is important. Mental health providers must remember that increased health symptom reporting is unlikely to be exclusively psychogenic in origin (Proctor et al., 1998).

Methods of Care: Overview

Management of acute stress reactions and problems faced by recently returned veterans are highlighted below. Methods of care for the Iraq War veteran with PTSD will be similar to those provided to veterans with chronic PTSD.

Education about post-traumatic stress reactions. Education is a key component of care for the veteran returning from war experience and is intended to improve understanding and recognition of symptoms, reduce fear and shame about symptoms, and, generally, “normalize” his or her experience. It should also provide the veteran with a clear understanding of how recovery is thought to take place, what will happen in treatment, and, as appropriate, the role of medication. With such understanding, stress reactions may seem more predictable and fears about long-term effects can be reduced. Education in the context of relatively recent traumatization (weeks or months) should include the conception that many symptoms are the result of psychobiological reactions to extreme stress and that, with time, these reactions, in most cases, will diminish. Reactions should be interpreted as responses to overwhelming stress rather than as personal weakness or inadequacy. In fact, some recent research (e.g., Steil & Ehlers, 2000) suggests that survivors’ own responses to their stress symptoms will in part determine the degree of distress associated with those symptoms and whether they will remit. Whether, for example, post-trauma intrusions cause distress may depend in part on their meaning for the person (e.g., “I’m going crazy”).

Training in coping skills. Returning veterans experiencing recurrent intrusive thoughts and images, anxiety and panic in response to trauma cues, and feelings of guilt or intense anger are likely to feel relatively powerless to control their emotions and thoughts. This helpless feeling is in itself a trauma reminder. Because loss of control is so central to trauma and its attendant emotions, interventions that restore self-efficacy are especially useful.

Coping skills training is a core element in the repertoire of many VA and Vet Center mental health providers. Some skills that may be effective in treating Iraq War veterans include: anxiety management (breathing retraining and relaxation), emotional “grounding,” anger management, and communication. However, the days, weeks, and months following return home may pose specific situational challenges; therefore, a careful assessment of the veteran’s current experience must guide selection of skills. For example, training in communication skills might focus on the problem experienced by a veteran in expressing positive feelings towards a partner (often associated with emotional numbing); anger management could help the veteran better respond to others in the immediate environment who do not support the war.

Whereas education helps survivors understand their experience and know what to do about it, coping skills training should focus on helping them know *how* to do the things that will support recovery. It relies on a cycle of instruction that includes education, demonstration, rehearsal with feedback and coaching, and repeated practice. It includes regular between-session task assignments with diary self-monitoring and real-world practice of skills. It is this repeated practice and real world experience that begins to empower the veteran to better manage his or her challenges (see Najavits, 2002, for a useful manual of trauma-related coping skills).

Exposure therapy. Exposure therapy is among the best-supported treatments for PTSD (Foa et al., 2000). It is designed to help veterans effectively confront their trauma-related emotions and painful memories, and can be distinguished from simple discussion of traumatic experience in that it emphasizes *repeated* verbalization of traumatic memories (see Foa & Rothbaum, 1998, for a detailed exposition of the treatment). Patients are exposed to their own individualized fear stimuli repetitively, until fear responses are consistently diminished. Often, in-session exposure is supplemented by therapist-assigned and monitored self-exposure to the memories or situations associated with traumatization. In most treatment settings, exposure is delivered as part of a more comprehensive “package” treatment; it is usually combined with traumatic stress education, coping skills training, and, especially, cognitive restructuring (see below). Exposure therapy can help correct faulty perceptions of danger, improve perceived self-control of memories and accompanying negative emotions, and strengthen adaptive coping responses under conditions of distress.

Cognitive restructuring. Cognitive therapy or restructuring, one of the best-validated PTSD treatments (Foa et al., 2000), is designed to help the patient review and challenge distressing trauma-related beliefs. It focuses on educating participants about the relationships between thoughts and emotions, exploring common negative thoughts held by trauma survivors, identifying personal negative beliefs, developing alternative interpretations or judgments, and practicing new thinking. This is a systematic approach that goes well beyond simple discussion of beliefs to include individual assessment, self-monitoring of thoughts, homework assignments, and real-world practice. In particular, it may be a most helpful approach to a range of emotions other than fear – guilt, shame, anger, depression – that may trouble veterans. For example, anger may be fueled by negative beliefs (e.g., about perceived lack of preparation or training for war experiences, about harm done to their civilian career, about perceived lack of support from civilians). Cognitive therapy may also be helpful in helping veterans cope with distressing changed perceptions of personal identity that may be associated with participation in war or loss of wartime identity upon return (Yerkes & Holloway, 1996).

A useful resource is the Cognitive Processing Therapy manual developed by Resick and Schnicke (1993), which incorporates extensive cognitive restructuring and limited exposure. Although designed for application to rape-related PTSD, the methods can be easily adapted for use with veterans. Kubany’s (1998) work on trauma-related guilt may be helpful in addressing veterans’ concerns about harming or causing death to civilians.

Family counseling. Mental health professionals within VA and Vet Centers have a long tradition of working with family members of veterans with PTSD. This same work, including family education, weekend family workshops, couples counseling, family therapy, parenting classes, or training in conflict resolution, will be very important with Iraq War veterans. Some issues in family work are discussed in more detail below.

Early Interventions for ASD or PTSD

If Iraq War veterans arrive at VA Medical Centers very soon (i.e., within several days or several weeks) following their trauma exposure, it is possible to use an early intervention to try to prevent development of PTSD. Although cognitive-behavioral early interventions have only been developed recently and have not yet been tried with war-related ASD, they should be considered as a treatment option for some returning veterans, given their impact with other traumas and consistency with what is known about treatment of more chronic PTSD. In civilian populations, several randomized controlled trials have demonstrated that brief (i.e., 4-5 session) individually-administered cognitive-behavioral treatment, delivered around two weeks after a trauma, can prevent PTSD in some survivors of motor vehicle accidents, industrial accidents, and assault (Bryant et al., 1998, 1999) who meet criteria for ASD.

This treatment is comprised of education, breathing training/relaxation, imaginal and *in vivo* exposure, and cognitive restructuring. The exposure and cognitive restructuring elements of the treatment are thought to be most helpful. A recent unpublished trial conducted by the same team compared cognitive therapy and exposure in early treatment of those with ASD, with results indicating that both treatments were effective with fewer patients dropping out of cognitive therapy. Bryant and Harvey (2000) noted that prolonged exposure is not appropriate for everyone (e.g., those experiencing acute bereavement, extreme anxiety, severe depression, those experiencing marked ongoing stressors or at-risk for suicide). Cognitive restructuring may have wider applicability in that it may be expected to produce less distress than exposure.

Toxic Exposure, Physical Health Concerns, and Mental Health

War syndromes have involved fundamental, unanswered questions about chronic somatic symptoms in armed conflicts since the U.S. civil war (Hyams et al., 1996). In recent history, unexplained symptoms have been reported by Dutch peacekeepers in Lebanon, Bosnia, and Cambodia, Russian soldiers in Afghanistan and Chechnya, Canadian peacekeepers in Croatia, soldiers in the Balkan war, individuals exposed to the El Al airliner crash, individuals given the anthrax vaccine, individuals exposed to the World Trade Center following 9/11, and soldiers in the Gulf War. Seventeen percent of Gulf War veterans believe they have “Gulf War Syndrome” (Chalder et al., 2001).

Besides PTSD, modern veterans may experience a range of “amorphous stress outcomes” (Engel, 2001). Factors contributing to these more amorphous syndromes include suspected toxic exposures, and ongoing chronic exhaustion and uncertainty. Belief in exposure to toxic contaminants has a strong effect on symptoms. Added to this, mistrust of military and industry, intense and contradictory media focus, confusing scientific debates, and stigma and medicalization can contribute to increased anxiety and symptoms.

When working with a recent veteran, the clinician needs to address a full range of potentially disabling factors: harmful illness beliefs, weight and conditioning, diagnostic labeling, unnecessary testing, misinformation, over-medication, all or nothing rehabilitation approaches, medical system rejection, social support, and workplace competition. The provider needs to be familiar with side effects of suspected toxins so that he or she can educate the veteran, as well as being familiar with the potential somatic symptoms that are related to prolonged exposure to combat stressors, and the side effects of common medications. The provider should take a collaborative approach with the

patient, identifying the full range of contributing problems, patient goals and motivation, social support, and self-management strategies. A sustained follow-up is recommended.

For those with inexplicable health problems, Fischhoff and Wessely (2003) outlined some simple principles of patient management that may be useful in the context of veteran care:

- Focus communication around patients' concerns
- Organize information coherently
- Give risks as numbers
- Acknowledge scientific uncertainty
- Use universally understood language
- Focus on relieving symptoms

There is evidence that both cognitive-behavioral group therapy (CBGT) and exercise are effective for treating Gulf War illness. In a recent clinical trial, Donata et al. (2003) reported that CBGT improved physical function whereas exercise led to improvement in many of the symptoms of Gulf War veterans' illnesses. Both treatments improved cognitive symptoms and mental health functioning, but neither improved pain. In this study, CBGT was specifically targeted at physical functioning, and included time-contingent activity pacing, pleasant activity scheduling, sleep hygiene, assertiveness skills, confrontation of negative thinking and affect, and structured problem solving skills. The low-intensity aerobic exercise intervention was designed to increase activity level by having veterans exercise once per week for one hour in the presence of an exercise therapist, and independently 2-3 times per week. These findings are important because they demonstrate that such treatments can be feasibly and successfully implemented in the VA health care system, and thus should be considered for the treatment of Iraq War veterans who present with unexplained physical symptoms.

Family Involvement in Care

The primary source of support for the returning soldier is likely to be his or her family. We know from veterans of the Vietnam War that there can be a risk of disengagement from family at the time of return from a war zone. We also know that emerging problems with ASD and PTSD can wreak havoc with the competency and comfort the returning soldier experiences as a partner and parent. While the returning soldier clearly needs the clinician's attention and concern, that help can be extended to include his or her family as well. Support for the veteran and family can increase the potential for the veteran's smooth immediate or eventual reintegration back into family life, and reduce the likelihood of future more damaging problems.

Outpatient treatment. If the veteran is living at home, the clinician can meet with the family and assess with them their strengths and challenges and identify any potential risks. Family and clinician can work together to identify goals and develop a treatment plan to support the family's reorganization and return to stability in coordination with the veteran's work on his or her own personal treatment goals.

If one or both partners are identifying high tension or levels of disagreement, or the clinician is observing that their goals are markedly incompatible, then issues related to safety need to be assessed and plans might need to be made that support safety for all family members. Couples who have experienced domestic violence and/or infidelity are at particularly high risk and in need

of more immediate support. When couples can be offered a safe forum for discussing, negotiating, and possibly resolving conflicts, that kind of clinical support can potentially help to reduce the intensity of the feelings that can become dangerous for a family. Even support for issues to be addressed by separating couples can be critically valuable, especially if children are involved and the parents anticipate future co-parenting.

Residential rehabilitation treatment. Inpatient hospitalization could lengthen the time returning personnel are away from their families, or it could be an additional absence from the family for the veteran who has recently returned home. It is important to the ongoing support of the reuniting family that clinicians remain aware that their patient is a partner and/or parent. Family therapy sessions, in person or by phone if geographical distance is too great, can offer the family a forum for working toward meeting their goals. The potential for involving the patient's family in treatment will depend on their geographic proximity to the treatment facility. Distance can be a barrier, but the family can still be engaged through conference phone calls, or visits as can be arranged.

Pharmacotherapy

Pharmacologic treatment of acute stress reactions. Pharmacological treatment for acute stress reactions (within one month of the trauma) is generally reserved for individuals who remain symptomatic after having already received brief crisis-oriented psychotherapy. This approach is in line with the deliberate attempt by military professionals to avoid medicalizing stress-related symptoms and to adhere to a strategy of immediacy, proximity, and positive expectancy.

Prior to receiving medication for stress-related symptoms, the war zone survivor should have a thorough psychiatric and medical examination, with special emphasis on medical disorders that can manifest with psychiatric symptoms (e.g., subdural hematoma, hyperthyroidism), potential psychiatric disorders (e.g., acute stress disorder, depression, psychotic disorders, panic disorder), use of alcohol and substances of abuse, use of prescribed and over-the-counter medication, and possible drug allergies. It is important to assess the full range of potential psychiatric disorders, and not just PTSD, since many symptomatic soldiers will be at an age when first episodes of schizophrenia, mania, depression, and panic disorder are often seen.

In some cases a clinician may need to prescribe psychotropic medications even before completing the medical or psychiatric examination. The acute use of medications may be necessary when the patient is dangerous, extremely agitated, or psychotic. In such circumstances the patient should be taken to an emergency room; short acting benzodiazepines (e.g., lorazepam) or high potency neuroleptics (e.g., Haldol) with minimal sedative, anticholinergic, and orthostatic side effects may prove effective. Atypical neuroleptics (e.g., risperidone) may also be useful for treating aggression.

When a decision has been made to use medication for acute stress reactions, rational choices may include benzodiazepines, antiadrenergics, or antidepressants. Shortly after traumatic exposure, the brief prescription of benzodiazepines (4 days or less) has been shown to reduce extreme arousal and anxiety and to improve sleep. However, early and prolonged use of benzodiazepines is contraindicated, since benzodiazepine use for two weeks or longer has actually been associated with a higher rate of subsequent PTSD.

Although antiadrenergic agents including clonidine, guanfacine, prazosin, and propranolol have been recommended (primarily through open non-placebo controlled treatment trials) for the

treatment of hyperarousal, irritable aggression, intrusive memories, nightmares, and insomnia in survivors with chronic PTSD, there is only suggestive preliminary evidence of their efficacy as an acute treatment. Of importance, antiadrenergic agents should be prescribed judiciously for trauma survivors with cardiovascular disease due to potential hypotensive effects and these agents should also be tapered, rather than discontinued abruptly, in order to avoid rebound hypertension. Further, because antiadrenergic agents might interfere with counterregulatory hormone responses to hypoglycemia, they should not be prescribed to survivors with diabetes.

Finally, the use of antidepressants may make sense within four weeks of war, particularly when trauma-related depressive symptoms are prominent and debilitating. To date, there has been one published report on the use of antidepressants for the treatment of Acute Stress Disorder. Recently-traumatized children meeting criteria for Acute Stress Disorder, who were treated with imipramine for two weeks, experienced significantly greater symptom reduction than children who were prescribed chloral hydrate.

Pharmacologic treatment of posttraumatic stress disorder. Pharmacotherapy is rarely used as a stand-alone treatment for PTSD and is usually combined with psychological treatment. The following text briefly presents recommendations for the pharmacotherapeutic treatment of PTSD, and then the article by Friedman, Donnelly, and Mellman (2003) in Appendix H provides more detailed information. Findings from subsequent large-scale trials with paroxetine have demonstrated that SSRI treatment is clearly effective both for men in general and for combat veterans suffering with PTSD.

We recommend SSRIs as first line medications for PTSD pharmacotherapy in men and women with military-related PTSD. SSRIs appear to be effective for all three PTSD symptom clusters in both men and women who have experienced a variety of severe traumas and they are also effective in treating a variety of co-morbid psychiatric disorders, such as major depression and panic disorder, which are commonly seen in individuals suffering with PTSD. Additionally, the side effect profile with SSRIs is relatively benign (compared to most psychotropic medications) although arousal and insomnia may be experienced early on for some patients with PTSD.

Second line medications include nefazadone, TCAs, and MAOIs. Evidence favoring the use of these agents is not as compelling as for SSRIs because many fewer subjects have been tested at this point. The best evidence from open trials supports the use of nefazadone, which like SSRIs promotes serotonergic actions and is less likely than SSRIs to cause insomnia or sexual dysfunction. Trazadone, which has limited efficacy as a stand-alone treatment, has proven very useful as augmentation therapy with SSRIs; its sedating properties make it a useful bedtime medication that can antagonize SSRI-induced insomnia. Despite some favorable evidence of the efficacy of MAOIs, these compounds have received little experimental attention since 1990. Venlafaxine and bupropion cannot be recommended because they have not been tested systematically in clinical trials.

There is a strong rationale from laboratory research to consider antiadrenergic agents. It is hoped that more extensive testing will establish their usefulness for PTSD patients. The best research on this class of agents has focused on prazosin, which has produced marked reduction in traumatic nightmares, improved sleep, and global improvement in veterans with PTSD. Hypotension and sedation need to be monitored. Patients should not be abruptly discontinued from antiadrenergics.

Despite suggestive theoretical considerations and clinical findings, there is only a small amount of evidence to support the use of carbamazepine or valproate with PTSD patients. Further, the complexities of clinical management with these effective anticonvulsants have shifted current attention to newer agents (e.g., gabapentin, lamotrigine, and topiramate), which have yet to be tested systematically with PTSD patients.

Benzodiazepines cannot be recommended for patients with PTSD. They do not appear to have efficacy against core PTSD symptoms. No studies have demonstrated efficacy for PTSD-specific symptoms.

Conventional antipsychotics cannot be recommended for PTSD patients. Preliminary results suggest, however, that atypical antipsychotics may be useful, especially to augment treatment with first or second line medications, especially for patients with intense hypervigilance or paranoia, agitation, dissociation, or brief psychotic reactions associated with their PTSD. As for side effects, all atypicals may produce weight gain and olanzapine treatment has been linked to the onset of Type II diabetes mellitus.

General guidelines. Pharmacotherapy should be initiated with SSRI agents. Patients who cannot tolerate SSRIs or who show no improvement might benefit from nefazadone, MAOIs, or TCAs.

For patients who exhibit a partial response to SSRIs, one should consider continuation or augmentation. A recent trial with sertraline showed that approximately half of all patients who failed to exhibit a successful clinical response after 12 weeks of sertraline treatment, did respond when SSRI treatment was extended for another 24 weeks. Practically speaking, clinicians and patients usually will be reluctant to stick with an ineffective medication for 36 weeks, as in this experiment. Therefore, augmentation strategies seem to make sense. Here are a few suggestions based on clinical experience and pharmacological “guesstimates,” rather than on hard evidence:

- Excessively aroused, hyperreactive, or dissociating patients might be helped by augmentation with an antiadrenergic agent;
- Labile, impulsive, and/or aggressive patients might benefit from augmentation with an anticonvulsant;
- Fearful, hypervigilant, paranoid, and psychotic patients might benefit from an atypical antipsychotic.

Integrating Iraq War Soldiers into Existing Specialized PTSD Services

Iraq War service members with stress-related problems may need to be integrated into existing VA PTSD Residential Rehabilitation Programs or other VA mental health programs. Approaches to this integration of psychiatric evacuees will vary and each receiving site will need to determine its own “best fit” model for provision of services and integration of veterans. At the National Center’s PTSD Residential Rehabilitation Program in the VA Palo Alto Health Care System, it is anticipated that Iraq War patients will generally be integrated with the rest of the milieu (e.g., for community meetings, affect management classes, conflict resolution, communication skills training), with the exception of identified treatment components. The latter elements of treatment, in which Iraq War veterans will work together, will include process, case management, and acute stress/PTSD education groups (and, if delivered in groups, exposure therapy, cognitive restructuring, and

family/couples counseling). The thoughtful mixing of returning veterans with veterans from other wars/conflicts is likely, in general, to enhance the treatment experience of both groups.

Practitioner Issues

Working with Iraq War veterans affected by war zone trauma is likely to be emotionally difficult for therapists. It is likely to bring up many feelings and concerns - reactions to stories of death and great suffering, judgments about the morality of the war, reactions to patients who have killed, feelings of personal vulnerability, feelings of therapeutic inadequacy, perceptions of a lack of preparation for acute care - that may affect ability to listen empathically to the patient and maintain the therapeutic relationship (Sonnenberg, 1996). Koshes (1996) suggested that those at greatest risk for strong personal reactions might be young, inexperienced staff who are close in age to patients and more likely to identify with them, and technicians or paraprofessional workers who may have less formal education about the challenges associated with treating these patients but who actually spend the most time with patients. Regardless of degree of experience, all mental health workers must monitor themselves and practice active self-care, and managers must ensure that training, support, and supervision are part of the environment in which care is offered.

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