

### 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.