IV. Treatment of the Returning Iraq War Veteran

Josef I. Ruzek, Ph.D., Erika Curran, M.S.W., Matthew J. Friedman, M.D., Ph.D., Fred D. Gusman, M.S.W., Steven M. Southwick, M.D., Pamela Swales, Ph.D., Robyn D. Walser, Ph.D., Patrician J. Watson, Ph.D., and Julia Whealin, Ph.D.

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, Fischoff 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 has 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 pharmaco-therapeutic 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 buproprion 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. Iit 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 topirimate), 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 patients. 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.

References and Additional Resources

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