

Post Traumatic Stress Disorder Therapies for Military Veterans

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Abstract

This paper offers a comprehensive review of various treatment modalities for Post-Traumatic Stress Disorder (PTSD) among war veterans, with a particular focus on the efficacy of different therapeutic interventions. Drawing upon a thorough literature review, this study examines the effectiveness of Cognitive Processing Therapy (CPT), exposure therapy, medication, and other approaches in addressing the complex needs of veterans grappling with PTSD symptoms. Key findings from the literature underscore the promising outcomes associated with CPT, which provides a structured framework for veterans to process traumatic experiences and reframe negative cognitions. Additionally, exposure therapy and pharmacotherapy emerge as viable options, albeit with varying degrees of success and side effects. Furthermore, this paper presents a compelling case study that highlights the journey of a young war veteran undergoing CPT treatment. Through a series of sessions, the veteran demonstrates progressive improvement in symptom management and overall well-being, showcasing the transformative potential of evidence-based interventions. In conclusion, this review underscores the importance of tailored and comprehensive approaches to PTSD treatment for war veterans. By integrating insights from both the literature and real-world case studies, this paper aims to inform clinicians, researchers, and policymakers about the most effective strategies for supporting veterans in their recovery from PTSD.

Keywords: PTSD, CPT treatment, War Veterans, Mental Health

Introduction

The experience of war leaves an indelible mark on those who serve in the armed forces, often resulting in profound psychological and emotional challenges long after the battlefields have been left behind. Among the most prevalent and debilitating of these challenges is Posttraumatic Stress Disorder (PTSD). Research indicates that PTSD affects a significant proportion of military veterans, with estimates suggesting that up to 20% of veterans from the Iraq and Afghanistan wars experience symptoms of PTSD. These symptoms can range from intrusive memories and flashbacks to hyperarousal and avoidance behaviors, profoundly impacting the daily lives and mental well-being of affected individuals.

Furthermore, the prevalence of PTSD among veterans is not static; it varies depending on factors such as the intensity and duration of combat exposure, deployment history, and the presence of co-occurring mental health conditions. Despite advancements in understanding and treating PTSD, many veterans continue to struggle with its debilitating effects. Moreover, the repercussions extend beyond the individual, affecting families, communities, and the broader society.

In light of these statistics, it becomes evident that addressing PTSD among veterans is not only a humanitarian imperative but also a pressing public health concern. This introduction aims to explore the

multifaceted nature of PTSD within the veteran population, emphasizing the need for comprehensive support, intervention, and advocacy to mitigate its impact and promote the well-being of those who have served their country.

Literature Review

Bruce E. et al. (2010), Many researchers acknowledge the superiority of trauma-focused treatments over non-trauma focused treatments for Post-Traumatic Stress Disorder (PTSD). However, Benish, Imel, and Wampold (2008) conducted a recent meta-analysis of clinical trials directly comparing various PTSD treatments. Their analysis did not reject the null hypothesis, suggesting that different PTSD treatments are similarly effective. They suggested that previous meta-analyses might have been influenced by factors such as the use of control treatments, which could have skewed conclusions about the relative efficacy of specific PTSD treatments. On the other hand, Ehlers et al. (2010) argued that the selection procedures of the Benish et al. meta-analysis were biased. They cited results from individual studies and previous meta-analyses indicating that trauma-focused psychological treatments outperform non-trauma focused treatments.[1]

In this paper, they provide a review and rationale for the coding criteria and procedure used in the Benish et al. meta-analysis. We also discuss the appropriateness of using treatments like 'supportive therapy' to control for non-specific factors when assessing the relative efficacy of specific PTSD treatments. Additionally, we highlight several other confounding factors in PTSD research, including therapist effects, allegiance, and protocol alterations, and describe conceptual issues with the classification scheme used to determine the "trauma focus" of interventions. These factors can lead to misguided conclusions about the effectiveness of treatments for PTSD.[1]

Brian A. (2011). This paper offers a comprehensive review of current pharmacological and psychological interventions aimed at preventing and treating PTSD, particularly in combat-related traumas and among veteran populations. Strong evidence supports the effectiveness of therapies such as prolonged exposure (PE), eye movement desensitization and reprocessing (EMDR), and cognitive processing therapies (CPT), with PE standing out for its extensive empirical support. While there have been fewer studies on non exposure-based modalities (such as psychodynamic, interpersonal, and dialectical behavior therapy perspectives), there is no indication that these treatments are less effective.[2]

Pharmacotherapy shows promise, especially with medications like paroxetine, sertraline, and venlafaxine, but further research comparing medication versus psychotherapy and exploring the efficacy of combined treatments is necessary. Given the increasing incidence of combat-related traumas due to ongoing conflicts in Iraq and Afghanistan, there is an urgent call for more randomized clinical trials and effectiveness studies in military and Department of Veterans Affairs PTSD samples.

Finally, the paper provides references to various PTSD treatment manuals and offers recommendations to assist clinicians in selecting appropriate treatments.[2]

Benjamin Kelmendi (2016). This paper has examined neurobiological irregularities in PTSD, exploring their connections to existing, potential, and forthcoming targets for pharmacological treatments. While abnormalities in various neurotransmitter systems have been linked to PTSD's pathophysiology, these systems don't operate uniformly in all PTSD patients. Current primary pharmacotherapy for PTSD yields suboptimal response rates. Emerging pharmacological targets for PTSD encompass the cannabinoid and oxytocin systems, along with agents that modulate glutamatergic activity. Future drug development for PTSD needs to target the diverse dimensions of PTSD symptomatology specifically.[3]

Joris F.G. et al. (2015). Soldiers and veterans diagnosed with PTSD seem to derive less benefit from psychotherapy compared to civilian populations. This recent meta-analysis aimed to identify treatment predictors specifically for traumatized soldiers and veterans, drawing from studies that examined guideline-recommended interventions, including EMDR, exposure therapy, various cognitive therapies, and stress management techniques. The analysis encompassed data from 57 eligible studies representing 69 treated samples.[4]

Key findings indicated that exposure therapy and cognitive processing therapy demonstrated greater effectiveness compared to EMDR and stress management therapy. Additionally, therapy formats that involved individual sessions or a combination of individual and group sessions outperformed group-only formats. Interestingly, after accounting for study design variables, EMDR no longer negatively predicted treatment outcomes. Moreover, the number of trauma-focused sessions, rather than the total number of therapy sessions, positively correlated with treatment outcomes.

Furthermore, the severity of PTSD symptoms prior to treatment was found to impact treatment outcomes, with lower and higher severity levels associated with less improvement compared to moderate severity levels. Notably, demographic variables did not seem to influence treatment outcomes significantly.

In conclusion, the study suggests that soldiers and veterans may benefit most from exposure interventions when addressing PTSD. Additionally, it indicates that group-only therapy formats may not be as effective. However, the effectiveness of recommended interventions appears to diminish at lower and higher levels of PTSD severity. The study emphasizes the need for future high-quality research to better understand the efficacy of EMDR and to refine treatment approaches for this population.[4]

Miriam Reisman (2016). Despite significant progress in understanding and treating PTSD symptoms, the increasing number of American veterans affected by the disorder remains a pressing national public health concern. While cognitive behavioral therapy stands as a widely endorsed treatment method, there's a pressing need to explore more effective pharmacological strategies for symptom management. It's evident that not all patients respond adequately to psychotherapy or evidence-based pharmacotherapy, underscoring the urgency of identifying alternative approaches.[5]

Deeper insights into the physiological and neurological underpinnings of PTSD are crucial for developing novel and more efficacious therapies. Research indicates potential avenues for the VA and other healthcare systems to innovate in overcoming barriers to treating veterans with PTSD. With veterans and their families increasingly seeking care beyond the VA system, community providers play a pivotal role in addressing these challenges. It's imperative that they receive the necessary education, training, and resources to enhance their understanding of and capacity to meet the unique needs of this population.[5]

Mathew J. et al. (2007). Iraq and Afghanistan War veterans were categorized based on the severity of their posttraumatic stress disorder (PTSD) symptoms and then compared regarding self-reported traits of anger, hostility, and aggression. Those veterans who screened positive for PTSD reported significantly higher levels of anger and hostility compared to both the subthreshold-PTSD and non-PTSD groups. Additionally, veterans in the subthreshold-PTSD category reported significantly greater anger and hostility compared to those in the non-PTSD group. Interestingly, while there was no significant difference in aggression between the PTSD and subthreshold-PTSD groups, both groups were notably more likely to endorse aggressive behavior compared to the non-PTSD group. These findings underscore the importance of healthcare providers screening for anger and aggression among Iraq and Afghanistan War veterans exhibiting PTSD symptoms and integrating appropriate anger management interventions into early intervention strategies.[6]

Meaghan C. (2018). While only a minority of military veterans develop Posttraumatic Stress Disorder (PTSD), much of the focus in mental health theory and research has been on PTSD and its treatment. Conversely, the considerable stress experienced by many, if not most, veterans during the transition to civilian life has received limited attention. This paper aims to address this gap by examining the broader spectrum of challenges, successes, failures, and rewards that transitioning veterans may encounter, along with the factors that may influence these experiences.

To support this argument, we briefly explore the process of becoming a soldier (i.e., the transition into military service) and, more importantly, the stressors veterans may face when attempting to relinquish that identity (i.e., the transition out of military service). We conclude by proposing avenues for expanding research on veteran transition stress and how to progress in this area.[7]

Case study

Tom is a 23 year old Male. He served in Iraq in the U.S military, he had a traumatic experience there which led him to have PTSD. He was given Cognitive processing treatment while on active duty in the Army which was continued after being discharged from the army.

It consisted of 12 sessions with the Psychologist. Take home Assignments were also given. Each Session lasted for an hour, the focus would be on Tom's feelings in reaction to the traumatic event.

Session 1

The purposes of the first therapy session were to (1) describe the symptoms of PTSD; (2) give Tom a framework for understanding why these symptoms had not remitted; (3) present an overview of treatment to help Tom understand why practice outside of session and therapy attendance were important to elicit cooperation and to explain the progressive nature of the therapy; (4) build rapport between Tom and the therapist; and (5) give the client an opportunity to talk briefly about his most distressing traumatic event or other issues.

Session 2

The purposes of the second session were (1) to discuss the meaning of the event and (2) to help Tom begin to recognize thoughts, label emotions, and see the connection between what he says to himself and how he feels.

Session 3

Tom handed the therapist his practice assignments as soon as he arrived. The therapist went over the individual A-B-C Sheets Tom had completed and emphasized that he had done a good job in identifying his feelings and recognizing his thoughts. The purpose of reviewing this work at this point in the therapy is to identify thoughts and feelings, not to heavily challenge the content of those thoughts.

Session 4

During the settling-in portion of the session, Tom indicated that he had written the account of the event the evening before, although he had thought about and dreaded it every day prior to that. He admitted that he had been avoidant due to his anxiety. The therapist asked Tom to read his account aloud to her. Before starting, Tom asked why it was important to read it in the session. The therapist reminded Tom of what they had talked about the previous session, and added that the act of reading aloud would help him to access the whole memory and his feelings about it.

Session 5

Tom arrived at Session 5 looking brighter and making more eye contact with the therapist. He indicated that he had written the account again, right after the previous session. He commented that the writing was

hard, but not as hard as the first time. The therapist used this as an opportunity to reinforce how natural emotions resolve naturally as they are allowed expression. Tom noted that he had talked with his wife more this week, avoiding her less. Their increased communication allowed Tom's wife to express her concerns about Tom's well-being. She shared that he seemed disinterested in her and in their unborn child. Tom had previously told his wife about the incident, but he had not shared the specific detail that the woman in the vehicle was pregnant. Tom perceived his wife as having a very good reaction to his disclosure about the pregnant woman. He noted that she asked him questions, and that her comments indicated that she did not blame him for his actions. For example, she asked, "How could you have known at the time that it was a family?" She also reportedly said, "It's hard to know with terrorism if they were actually just a family traveling." Tom laughed when he reported that their conversation sounded like his last psychotherapy session.

Session 6

Tom completed Challenging Questions Sheets about all of the stuck points he and the therapist had generated. The therapist reviewed these worksheets to determine whether Tom had used the questions as designed. She asked Tom which of the worksheets he had found least helpful. He responded that he had had the most difficulty completing the sheet about deserving to have a family. The therapist then reviewed this sheet in detail with Tom.

Session 7

Tom began the session by stating that he was feeling better, and that his wife had also noted a difference in him and was feeling less concerned about the therapy making him worse rather than better. The therapist had given Tom the PCL and the BDI-II to complete while he was waiting for his appointment. She quickly scored these assessment measures and gave Tom feedback about his scores at the beginning of this session. His PCL score had decreased from 68 to 39, which was a clear and clinically meaningful change in his PTSD symptomatology. She noticed that his avoidance and reexperiencing symptoms had decreased the most; his hyperarousal symptoms had also decreased, but less so. His score on the BDI-II had decreased from 28 to 14, clearly indicating a reduction in his depressive symptoms. In this session, the therapist introduced the Challenging Beliefs Worksheet. She was careful to point out that the worksheet integrated all of the previous work Tom had done and added a few new elements.

Session 8

Tom completed two Challenging Beliefs Worksheets related to the topic of safety, as the therapist had instructed. He did one each on self and other safety beliefs. He did not seem to understand that he could use the Challenging Beliefs Worksheets on everyday events that were distressing or even positive for him. Thus, the therapist emphasized how Tom might use this process more generally in his day-to-day life, and highlighted how more practice would lead to more results. She noted that using the process on less emotionally distressing topics could actually be very helpful in getting the process down. It is always easier to learn something when one is not dealing with the most challenging circumstances. She used a military analogy with Tom about learning to load and shoot a gun—best learned in a nonconflict situation, so that it is a more rote behavior when under fire. The therapist skimmed the two sheets Tom had completed and noticed that he had struggled most coming up with alternative statements about his own sense of dangerousness related to his wife's impending delivery of their child.

Session 9

The therapist praised Tom for completing the worksheets so well, and asked him whether he felt he could use assistance with any of the worksheets. Tom quickly responded that he wanted to focus on the sheet

about fatherhood because he was experiencing so much anxiety about his child's impending birth. In turning their attention to this worksheet, the therapist immediately noticed that Tom had probably struggled with this work sheet because he had listed so many different types of thoughts that were fueling his anxiety about becoming a father. She used this as an opportunity to fine-tune Tom's use of the worksheets. The therapist's choice in thoughts to challenge first also illustrates the prioritization of treatment targets in the therapy. She chose to go after the more directly trauma-related thoughts that contained remnants of assimilation. Tom's thoughts about deserving to be happy about starting a family, given the death of the woman, fetus, and child, suggested that he had not fully accepted the traumatic event and the circumstances surrounding it.

Session 10

Tom stated that since reading the Power/Control module after the last session, he had started to realize that not everyone in authority over him had wielded his/ her authority malevolently. This was very important in light of Tom's preexisting history of desiring to exert control; he had directly confronted his illusion of control. The therapist and Tom went over this worksheet. Tom went on to describe how his belief that he could and should have control over everything had resulted in low self-esteem. In general, when things did not go as he desired, Tom felt as though he was a failure for not controlling the outcome. This belief structure led him to think that he should have been able to control his friend and stop him from committing suicide. It also led him to believe that he should have been able to create a positive outcome in the military traumatic event. This discussion served as a natural segue to the next topic—esteem. Tom admitted that he had become someone who thrived too much on accomplishment. This had affected his self-esteem and was especially relevant to his belief that he had not accomplished his goal in the military because he had to be taken from the field after the traumatic event at the checkpoint. After reviewing the Esteem module, the therapist asked Tom to complete Challenging Beliefs Worksheets on his remaining stuck points, as well as any stuck points relating to esteem. He was also given two other assignments: to practice giving and receiving compliments every day, and to do one nice thing for himself every day that was not contingent on “achieving” something. These assignments were to help him with his self- and other-esteem.

Session 11

d themselves. The therapist inquired about the assignment of giving and receiving compliments. Tom replied that it had gone well, even though it felt a bit awkward and forced. He was even able to notice that when he gave compliments and was more positive toward other people, he seemed to get more positive responses back from them. The therapist noticed that several of the compliments were to his wife, and she pointed out that Tom seemed more connected to his wife. He said that he was actually beginning to feel glimmers of excitement about the birth of their child. He reported that he was still feeling some anxiety about becoming a father, and about how the labor and delivery would go, but that the anxiety was less and more manageable. When the therapist asked about Tom receiving compliments, he reported more difficulties. She asked what Tom typically did when he received compliments, and it became clear that he often deflected or minimized them. Correspondingly, Tom also said that he had only done one nice thing for himself since the last session, and that it had felt uncomfortable. This pattern seemed to fit with Tom's overall schema of being unworthy and undeserving.

Session 12

The therapist inquired about how the assignments had gone. Tom said that he had not done as much as he had hoped given the baby's arrival, but that he had done worksheets about his father and about being close

to his wife. The therapist looked over these worksheets, which Tom had done very well. She asked Tom about how helpful they had been, and he reported that they had been very helpful. He added that he was still struggling about his father, but that he was beginning to think that it was not all about him, which had made him feel better about himself and less guilty in general. He mentioned that he was considering writing a letter to his father about his daughter's arrival, and that he was thinking about asking his father about why he drank and distanced himself from his family. The therapist reinforced Tom for considering this and for not blindly making assumptions about his role in his father's drinking. However, she also attempted to inoculate Tom to the possibility that his father could blame him or his siblings for his alcoholism (given that she did not know his father or his history), and that this did not necessarily mean that it was true. She reminded him that he needed to consider the source of information, and that any good detective would get multiple reports. Tom seemed to like the idea of getting more information from others, mentioning that he and his siblings had never really talked about his belief that they were to blame for their father's alcoholism.

Tom also shared that he better understood the idea of having intimacy, without sex, in his relationship with his wife. He said that since the birth of their child, he felt closer to his wife and had generally been more open and present to her. The therapist asked him about doing nice things for himself, and Tom laughed and said that he was more open to that but was finding less time to do it with a new baby.

Conclusion

In conclusion, the treatment of PTSD among veterans is a multifaceted endeavor, but Cognitive Processing Therapy (CPT) stands out as a particularly effective method. Through a series of sessions tailored to address the individual's trauma, CPT offers a structured approach to reframe negative thoughts and emotions associated with the traumatic experience. While other methods exist, such as exposure therapy and medication, CPT has shown significant promise in alleviating symptoms and promoting recovery.

A case study exemplifies the transformative potential of CPT in the journey of a war veteran towards healing and rehabilitation. This veteran's progressive improvement underscores the importance of consistent therapeutic engagement and highlights the resilience and capacity for recovery within individuals affected by PTSD.

Ultimately, the efficacy of PTSD treatments for veterans lies not only in the methodologies employed but also in the commitment to providing comprehensive support and resources. By continuing to refine and implement evidence-based approaches like CPT, we can better serve those who have sacrificed for their country, offering them the opportunity to reclaim their lives and well-being.

References

1. Bruce E. et al. Determining what works in the treatment of PTSD. *Clinical Psychology Review*. 30 (2010). 923 -933. <http://dx.doi.org/10.1016/j.cpr.2010.06.005>
2. Brain A. et al. A Clinician's Guide to PTSD Treatments for Returning Veterans. *Professional Psychology: Research and Practice*. 42 (1). 2011. 8 - 15.
Doi : [10.1037/a0022351](https://doi.org/10.1037/a0022351)
3. Benjamin Kelmendi, Thomas G. Adams, Stephanie Yarnell, Steven Southwick, Chadi G. Abdallah & John H. Krystal (2016) PTSD: from neurobiology to pharmacological treatments, *European Journal of Psychotraumatology*, 7:1, 31858, DOI: [10.3402/ejpt.v7.31858](https://doi.org/10.3402/ejpt.v7.31858).

4. Joris F. et al. The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review*. 40 (2015). 184-194. <http://dx.doi.org/10.1016/j.cpr.2015.06.008>
5. Miriam Reisman. PTSD Treatment for Veterans: What's Working, What's New, and What's Next. *P&T*. 41 (10). 2016.
6. Mathew Jakupcak et al. Anger, Hostility, and Aggression Among Iraq and Afghanistan War Veterans Reporting PTSD and Subthreshold PTSD. *Journal of Traumatic Stress*. 20 (6). 2007. 945 - 954. DOI: [10.1002/jts.20258](https://doi.org/10.1002/jts.20258)
7. Meaghan C. et al. Beyond war and PTSD: The crucial role of transition stress in the lives of military veterans. *Clinical Psychology Review*. 59 (2018). 137 - 144. <https://doi.org/10.1016/j.cpr.2017.11.007>