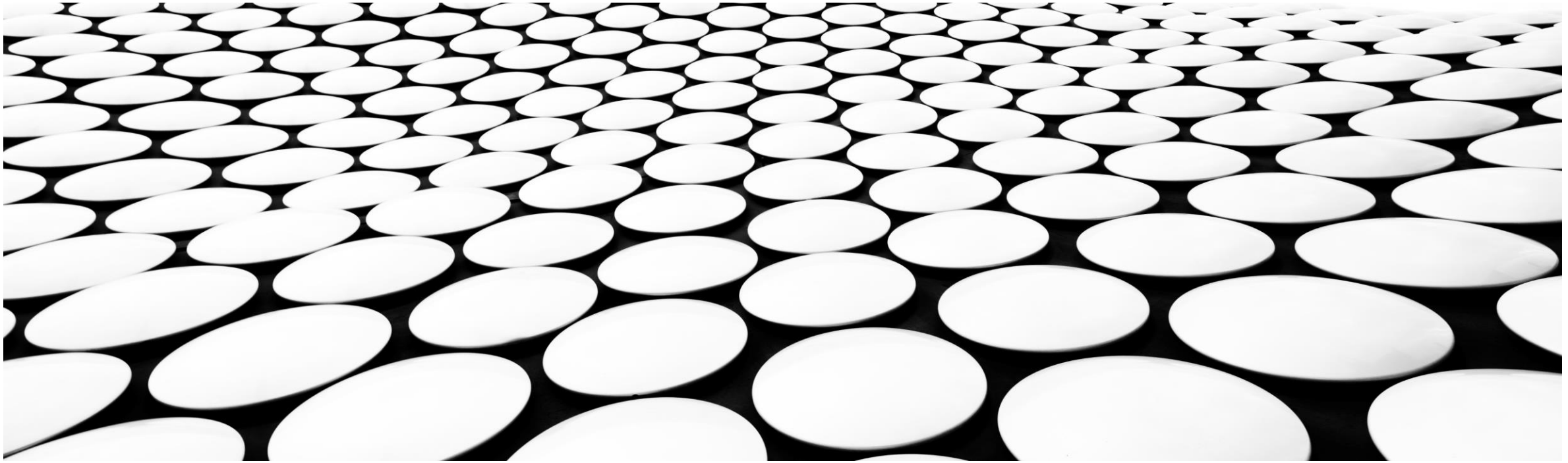
PTSD IN VETERANS

FRANK W. WEATHERS, PHD



DISCLOSURES

- I have nothing to disclose

OUTLINE OF PRESENTATION

- Historical context
- Unique aspects of military trauma
- The aftermath of war: Risk and resilience
- What to expect clinically working with veterans with PTSD

HISTORICAL CONTEXT

WHAT'S IN A NAME

- The psychological aftermath of war-related trauma has been described for thousands of years in literature, historical accounts, and clinical observations
- Various names for what we now recognize as PTSD:
  - **Civil War:** Soldier's heart, irritable heart syndrome, nostalgia
  - **WW I:** Shell shock, war neurosis, neurasthenia
  - **WW II:** Combat fatigue
  - **Korean War:** Combat exhaustion, gross stress reaction
  - **Vietnam War:** Post-Vietnam syndrome

EVOLVING CONCEPTUALIZATION OF STRESS RESPONSE TO WAR

- From physical causes to psychological causes
- From character flaw or cowardice to legitimate psychological injury
- From acute reaction to chronic, unremitting course
- From shame and punishment to treatment and recovery

CENTRAL ROLE OF WAR IN THE STUDY OF PSYCHOLOGICAL TRAUMA

- War-related trauma is a prototype of extreme stress
- Study of the psychological aftermath of war is a foundational literature in the field of traumatic stress
- Advocacy of veterans led to formal recognition of PTSD

UNIQUE ASPECTS OF MILITARY TRAUMA

NATURE OF COMBAT TRAUMA

- Repeated and prolonged exposure
  - Can lead to more complex clinical presentations and treatment resistance
- Moral injury
  - Witnessing, participating in, failing to prevent events that violate one's moral beliefs
  - Killing non-combatants, failing to save fellow service members, betrayal by leadership, atrocities
- Perpetrator vs. victim role
  - Veterans may have been both perpetrators and victims of violence
  - Creates complex guilt and identify issues

MILITARY CULTURE AND IDENTITY

- Warrior identity conflict
  - Military culture trains and reinforces hypervigilance, emotional numbing, and aggression, which become problematic in civilian life
- Stigma and help-seeking barriers
  - Seeking mental health help seen as weakness or failure
  - Symptoms are “just part of the job”
- Unit cohesion and survivor guilt
  - Intense bonds formed in military units don’t typically exist in civilian trauma
  - Loss of fellow service member leads to strong sense of survivor guilt

TRANSITION AND REINTEGRATION

- Civilian readjustment
  - Military service provides clear purpose, structure, identity
  - Civilian life may feel meaningless or chaotic
- Lifestyle overhaul
  - Reconnecting with family and community
  - Building new civilian identity
  - Struggles with education and employment
- Social isolation
  - Not fitting in, irritation with civilian values and norms
  - Withdrawal, fearful avoidance

THE AFTERMATH OF WAR: RISK AND RESILIENCE

MENTAL HEALTH TRAJECTORIES IN VETERANS

- **Resilient** (60-70%): Stable low distress, few mental health symptoms
- **Chronic distress** (10-20%): Stable high distress, PTSD, depression, substance use, suicidality
- **Recovery** (10-15%): Initial high distress, improvement over time, with or without formal treatment
- **Delayed onset** (5-10%): Initial low distress, increases months or years later

THE DEPLOYMENT RISK AND RESILIENCE INVENTORY-2 (DRRI-2)

- A wide range of environmental and personal factors influence response to war
- The DRRI-2 assesses 17 risk and resilience factors
  - Predeployment
  - Deployment
  - Postdeployment

DRRI-2: PREDEPLOYMENT FACTORS

- **Prior stressors**: Exposure to other traumatic events
- **Childhood family functioning**: Communication and closeness in family of origin

DRRI-2: DEPLOYMENT FACTORS – MISSION-RELATED

- **Difficult living and working environment:** Daily discomforts or deprivations (food, privacy, living arrangements, climate, culture)
- **Combat experiences:** Firing a weapon, being fired on, being attacked, friendly fire, going on patrols
- **Aftermath of battle:** Consequences of combat (human remains, POWs, devastated communities, refugees)

DRRI-2: DEPLOYMENT FACTORS – MISSION-RELATED

- **NBC exposures**: Nuclear, biological, and chemical agents
- **Perceived threat**: Fear for one's safety, emotional and cognitive appraisals that might not match objective reality
- **Preparedness:** Extent to which individual perceives they were prepared for deployment in terms of training, equipment, supplies, role in deployment, expectations about the region, how to operate as a unit

DRRI-2: DEPLOYMENT FACTORS – INTERPERSONAL

- **Deployment support from family and friends**
- **Unit social support:** Camaraderie with peers, trust in unit leaders
- **General harassment:** Non-sexual harassment based on biological sex, minority or other social status

DRRI-2: DEPLOYMENT FACTORS – INTERPERSONAL

- **Sexual harassment:** Including sexual remarks, unwanted touch, sexual assault
- **Concerns about life and family disruptions:** Relationships with spouse and children, missing significant events, career-related concerns
- **Family stressors:** Illness, infidelity, financial problems, end of a relationship

DRRI-2: POSTDEPLOYMENT FACTORS

- **Postdeployment stressors:** Other traumatic events, challenges with reintegration, including job interruption, financial difficulties, divorce
- **Postdeployment social support:** Emotional sustenance, instrumental assistance
- **Postdeployment family functioning:** Communication, closeness

WHAT TO EXPECT CLINICALLY WORKING WITH VETERANS WITH PTSD

COMPLEX TRAUMA HISTORY

- Multiple, varied trauma exposures
  - Life-threatening combat episodes
  - Witnessing or causing death
  - Moral injury
  - Sexual trauma
- Cumulative stress
- Difficulty identifying a single index event for assessment
- **Implication:** Take a thorough trauma history, expect continued disclosures over time, especially events involving moral injury

HIGH SYMPTOM SEVERITY AND CHRONICITY

- Symptoms likely to be severe, persistent, and resistant to treatment
- Typically, endorsement of virtually all PTSD symptoms, but particularly high levels of
  - Avoidance
  - Negative beliefs about self, others, and the world
  - Emotional numbing (anhedonia, social isolation, loss of positive emotions)
  - Hyperarousal (especially hypervigilance, problems with concentration and sleep)
- Maladaptive coping behaviors may be overlearned and normalized

HIGH COMORBIDITY

- Multiple co-occurring conditions
  - Depression
  - Traumatic brain injury
  - Substance use disorders
  - Chronic pain
  - Suicidality
- **Implication:** Conduct thorough assessment and develop a case formulation. May require multiple treatment modalities, multi-disciplinary approach, sequencing of interventions

COMPLEX EMOTIONAL REACTIONS

- Fear from direct experience of life threat
- Grief from loss and unresolved emotional bonds
- Guilt, shame, and spiritual or ethical conflict from moral injury
- Existential distress from exposure to death, loss of identity, lack of purpose and direction
- **Implication:** Use exposure to target fear, but also use interventions that address other emotions, e.g., CPT, ACT, adaptive disclosure

EMOTIONAL GUARDEDNESS

- Conditioned by military culture to “tough it out,” avoid vulnerability
- Resistance to discussing emotions, especially grief and shame
- May take the form of anger, detachment, cynicism, or even humor
- **Implications:** Go slow, build trust, engage authentically, explore costs of emotional restriction, use interventions focused on values, e.g., motivational interviewing, ACT

IDENTITY AND TRANSITION CHALLENGES

- Loss of mission, unit cohesion, role
- Feeling disconnected from civilians
- Struggling with existential questions, “who am I” and “what now”
- **Implications:** Address identity, values, and post-military purpose, e.g., with ACT. Explore options for peer support or veteran-focused programs

SUICIDALITY

- Compared to veterans without PTSD, those with PTSD are
  - 3.5 to 6 times more likely to attempt suicide
  - 2 to 4 times more likely to die by suicide
- Risk is especially elevated with comorbid TBI, depression, or substance use
- Certain PTSD symptoms are more predictive of suicidality
  - Emotional numbing
  - Hopelessness
  - Hyperarousal
  - Survival guilt

JOINER'S INTERPERSONAL THEORY OF SUICIDE

- Suicide occurs when three key factors converge
- Thwarted belongingness
  - Feeling disconnected, lonely, lacking meaningful relationships or social support, "I don't belong anywhere or with anyone"
- Perceived burdensomeness
  - Feeling like a burden to family, friends, society, "Others would be better off if I were dead"
- Acquired capability
  - The ability to overcome the natural human instinct for self preservation
  - Typically acquired through repeated exposure to painful or fear-inducing experiences, "Dying doesn't scare me"

APPLICATION TO PTSD

- PTSD activates all three components
- Thwarted belongingness
  - Emotional numbing, social withdrawal, alienation from family/friends, loss of unit cohesion
- Perceived burdensomeness
  - Worthlessness, shame, guilt from moral injury, belief that one's symptoms negatively impact loved ones, dependency on VA benefits or being unemployed due to disability
- Acquired capability
  - Desensitization to pain, exposure to death and violence, reckless or self-harming behavior, substance use
- Implication: Assess frequently for suicidality, target each of these components in treatment

CASE STUDY

- Angela R.
- Age: 38
- Air Force Security Forces 2008-1016
- 2 deployments to Afghanistan
- Current diagnoses of PTSD (chronic), major depressive disorder (moderate), alcohol misuse, current suicidal ideation

HISTORY OF PRESENT ILLNESS

- Referred to VA behavioral health clinic after disclosing passive SI during routine physical
- Often thinks “Everyone would be better off if I just disappeared”
- Reports nightmares, emotional numbing, avoidance of crowded places, detachment from loved ones
- Symptoms began after second deployment and worsened over past year due to job loss and social isolation

TRAUMA HISTORY

- **Childhood:** Physical abuse and neglect by family and sexual abuse by stepfather ages 9-11. Developed emotional suppression as survival strategy.
- **Combat:** Experienced rocket attacks and mass casualty event during deployment. Relives traumatic scenes, especially of injured civilians.
- **Moral injury:** Ordered warning shots during a mission, resulting in the death of a teenage boy who may have been deaf. Though she followed protocol, she suffers from profound guilt. She says “I did what I was trained to do, but I still killed someone’s child.”

SUICIDALITY

- She reports passive SI for over two years and recently began thinking about a plan. While she denies current intent, she says “I don’t fear death.” She agreed to give her firearm to a friend for safekeeping.

INTERPERSONAL THEORY OF SUICIDE

- **Thwarted belongingness:** Disconnected from civilians and veterans; estranged from family
- **Perceived burdensomeness:** Believes she is emotionally damaged, a failure in life, and a burden
- **Acquired capability:** Childhood physical and sexual abuse, combat, moral injury desensitized her to fear of death

TREATMENT PLAN

- Stabilization
  - Safety planning
  - Trauma psychoeducation
  - Grounding and affect regulation skills
  - Psychiatric consultation
- Trauma processing
  - Imaginal exposure for combat trauma
  - Adaptive disclosure: Empty-chair work for moral injury, imagined conversation with trusted mentor
  - Phase-based approach to childhood trauma: STAIR, including emotion regulation, interpersonal skills, cognitive reappraisal, building self-efficacy

TREATMENT PLAN

- Meaning and identity repair
  - Address grief and self-forgiveness
  - Peer-led women veterans' group engagement
  - Volunteering to reconnect with values

OUTCOME

- Reduced SI
- 40% improvement in PTSD symptoms
- Building new peer relationships
- Obtained steady employment
- “I still struggle, but now I feel like maybe I can forgive parts of myself

CLINICAL TAKEAWAYS

- Complex trauma requires layered, phased treatment
- Moral injury and suicidality often extend well beyond fear-based symptoms
- Female veterans in particular may present with underreported developmental trauma
- Peer support and meaning-making are critical to recovery

THE END — THANK YOU!

QUESTIONS OR COMMENTS?