INTRODUCTION

PTSD in the Military

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Throughout the centuries, philosophers, historians, researchers, and clinicians have given many names to the invisible wounds of combat. In the 5th century, Herodotus wrote of a brave warrior from the battle of Marathon who was rendered blind "without blow of sword or dart" as a fellow warrior next to him was struck down by the enemy (Waterfield, 2008). In the mid-18th century, the term "Swiss disease" was used to describe unexplained physical and psychological symptoms in Swiss villagers who were forced to serve in rogue armies (Jones, Sparacino, Wilcox, Rothberg, & Stokes, 1995). During the American Civil War, the Army physician J. M. Da Costa (1871) wrote of "irritable heart," which included symptoms we now label as panic. Other terms, such as "shell shock," "war neurosis," "battle fatigue," and "post-Vietnam syndrome" have followed.

It was not until 1980 that the American Psychiatric Association adopted the current term, "posttraumatic stress disorder" (PTSD), into its third edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Although the diagnostic criteria have evolved across subsequent iterations of the manual, this is the term we continue to use today, and the disorder on which this book is based. It is unlikely that any other psychiatric disorder in the last half-century has received so much attention. In part, the focus on PTSD arose from political pressures to label and categorize the psychological symptoms that Vietnam veterans were struggling with on their return home (Keane, 2009). It was also due in part to our inability to fully understand the differences in how individuals interpreted and reacted to trauma, as well as the concept of resiliency that has gained prominence in the field today. More recently, debates about the efficacy and applicability

of various psychotherapeutic, pharmacological, and complementary and alternative treatments permeate the psychological and medical literature, conferences, and popular media. At times it seems that clinicians either fall into the camps of manualized, evidence-based trauma-focused therapies (often supporting one while criticizing the others), somatic therapies, or "nontraditional" interventions with little clinical trial support but substantial anecdotal and historical support.

In this volume, the reader will find a compilation of chapters from top experts on the study and treatment of PTSD in service members and veterans. Many issues relevant to this area are covered in detail throughout the chapters. However, there are two salient points we feel deserve brief attention at the outset: the prevalence and significance of PTSD in the military and the need for better treatments.

Prevalence and Significance

It has been known for some time that service members and veterans are at increased risk of stress disorders due to their exposure to combat (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Prigerson, Maciejewski, & Rosenheck, 2002). Estimates of lifetime prevalence of PTSD for Vietnam veterans has been shown to be around 30% using broad criteria (Kulka et al., 1988) and approximately 19% when stricter criteria were applied (Dohrenwend et al., 2006).

Studies of veterans of the combat operations in Iraq and Afghanistan have shown significant levels of PTSD as well—however, there is some variability in prevalence reports. In a seminal study by Hoge and colleagues (2004) from the Walter Reed Army Institute of Research, four U.S. combat infantry units were given an anonymous survey either before their deployment to Iraq (n = 2,530) or, in a different cohort of troops, 3–4 months after their return from combat duty in Iraq or Afghanistan (n = 3,671). Results indicated that service members deployed to Iraq screened positive for PTSD at rates of 18–20% and those from Afghanistan at approximately 12%. Using the Post-Deployment Health Assessment (PDHA), Hoge, Auchterlonie, and Milliken (2006) found that approximately 10% of Iraq veterans and 5% of Afghanistan veterans screened positive for PTSD. A particularly strong aspect of this latter study is that it utilized the records of nearly a quarter of a million troops. A follow-up study by Milliken, Auchterlonie, and Hoge (2007), which included active-duty, National Guard, and reserve soldiers, revealed that approximately 17% of active-duty soldiers screened positive for PTSD at 3- to 6-months postdeployment. Levels for National Guard and reserve soldiers reached nearly 25%. In contrast, a later study revealed rates of approximately 7% in active-duty service members and 11% in National Guard service members at 12-months postdeployment

(Thomas et al., 2010). In a sample of nearly 2,000 Iraq and Afghanistan veterans, the RAND Corporation found a prevalence rate of nearly 14% (Tanielian & Jaycox, 2008). And then there are subthreshold symptoms of PTSD. It is estimated that approximately 8% of veterans battle clinically significant symptoms associated with trauma and military service, but do not reach the PTSD diagnostic threshold (Bergman, Przeworski, & Feeny, 2017).

Although variation exists in the estimated prevalence rates of PTSD in veterans of the Iraq and Afghanistan wars, the level of PTSD in our service members and veterans is significant. Even using the most conservative estimates—just considering veterans from the Iraq and Afghanistan wars—hundreds of thousands of military members are dealing with the aftereffects of military-related trauma. Furthermore, millions of loved ones are also affected by this disorder, and billions of dollars are spent each year in the attempt to better understand and prevent PTSD, as well as to rehabilitate those service members and veterans living with the disorder. It has rightly been placed at the top of the priority lists by the Departments of Defense and Veterans Affairs.

Need for Better Treatments

The evidence base for effective treatments for PTSD is lagging behind our knowledge about the mechanisms associated with the development, maintenance, and course of the disorder. In essence, a 2007 report by the Institute of Medicine (IOM) supported this claim.

After being commissioned by the U.S. Department of Veterans Affairs, the IOM was asked to review the current efficacy research on psychological and pharmacological treatments for PTSD. The IOM reviewed 90 randomized clinical trials (53 psychotherapeutic interventions and 37 pharmacological interventions) that focused on PTSD outcomes. The committee concluded that, based on their criteria, there was insufficient evidence to support the efficacy of pharmacological intervention for PTSD. Furthermore, exposure therapy was the only psychotherapeutic treatment modality shown to have sufficient evidence to support its use for PTSD.

Does this mean exposure therapy is the only treatment that works? No, absolutely not. Since 2007, additional research has shown that a variety of psychotherapies and medications can alleviate the burden of PTSD. As revealed in Department of Veterans Affairs/Department of Defense (VA/DoD) *Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (Management of Posttraumatic Stress Disorder Work Group, 2017), there is evidence supporting the use of other trauma-focused therapies such as cognitive processing therapy, brief eclectic psychotherapy, and eye movement desensitization

and reprocessing. Evidence also supports the use of non-trauma-focused therapies (often preferred by patients), such as stress inoculation training and interpersonal psychotherapy. For those patients who prefer pharmacotherapy, systemic reviews noted in the VA/DoD guidelines support the use of paroxetine, sertraline, fluoxetine, and venlafaxine. Unfortunately, few other medications are noted to have significant support for their use.

Even though the evidence for both pharmacological and psychotherapeutic treatments has grown since the first edition of this book was published, we have a long way to go. Dropout rates for trauma-focused therapies are a problem (Kehle-Forbes, Meis, Spoont, & Polusny, 2016) and many veterans prefer complementary and alternative approaches to wellness. Regarding the latter, it is frustrating that little attention and financial resources are expended to explore options other than exposure and cognitive therapies and medication for the treatment of PTSD. At times it seems that we continue to fund the same psychotherapies and pharmaceuticals at the cost of stifling innovation and minimizing the preferences of our combat veterans.

The Current Volume

This volume provides a snapshot of the most common, as well as emerging, treatments for service members and veterans suffering from PTSD and co-occurring disorders and related conditions. It will be of use to students and seasoned clinicians across psychology, social work, psychiatry, counseling, rehabilitation, and medicine.

Part I covers important cultural issues regarding working with military personnel (Chapter 1), effective assessment strategies (Chapter 2), and different treatment approaches (Chapters 3–13). Part II covers specific clinical issues associated with PTSD, such as co-occurring affective and anxiety and substance use disorders, traumatic brain injury, sexual trauma, and suicidal ideation (Chapters 14–20); and addresses important topics such as moral injury, complex trauma, and posttraumatic growth (Chapters 21–23). As a result of feedback from the field and emerging research, we added several chapters to the second edition to include stress inoculation training, mindfulness-based cognitive and behavioral therapies, complementary and alternative treatments, and others.

Although much of the material in this volume is exclusively related to the U.S. military, the information will likely be beneficial to clinicians, researchers, and students from different nations who work with service members and veterans. Our focus on the U.S. military is a direct consequence of our limited exposure to other national forces and not a lack of appreciation of the need to provide effective care for all men and women in uniform.

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