22 Considerations in the Treatment of Veterans with Posttraumatic Stress Disorder

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22.1 Introduction

> The soldier is the Army. No army is better than its soldiers. The soldier is also a citizen. In fact, the highest obligation and privilege of citizenship is that of bearing arms for one's country. – George S. Patton Jr.

Military service requires a commitment of service to one's country, motivated by very different passions which can range from the most patriotic to the most pragmatic. However, regardless of the reason a service member decides to enter military service, this commitment also demands a willingness to place oneself in situations that can mean exposure to unique stressors and traumas. As such, service members, particularly those who serve in combat, are at higher risk to experience potentially traumatic events. Traumatic events experienced while serving in the military may include not only exposure to combat and other life-threatening situations but also incidents that

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occur during rigorous training and interpersonal violence (e.g., military sexual harassment or assault). In turn, greater trauma exposure can place service members at increased risk for the subsequent development of stress-related mental health difficulties such as posttraumatic stress disorder (PTSD), depression, and alcohol misuse. The majority of studies examining the prevalence of PTSD among veterans have sampled those exposed to combat. Estimates of current PTSD prevalence in national samples have included 15.2 % of males and 8.1 % of females among veterans who served in the Vietnam War (Kulka et al. 1990), 10.1 % among those serving in the Gulf War (Kang et al. 2003), and 13.8 % among veterans of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF; Tanielian and Jaycox 2008). Veterans with PTSD have reported greater interpersonal disturbances (e.g., Koenen et al. 2008), lower occupational functioning (e.g., Zatzick et al. 1997), and reduced quality of life (e.g., Schnurr et al. 2006).

Delivering high-quality treatment to veterans with PTSD and other trauma-related conditions requires awareness not only of evidence-based treatment practices but also of military-related stressors and the underlying military cultural context in which they occur. In this chapter, we aim to provide the clinician with a greater understanding of military-related stressors and increased insight into the military cultural context. Important aspects of the military experience are introduced, and additional resources are provided so that the clinician can learn more about each topic. Please note that the majority of our review and recommendations are grounded largely in the experience of US military service and veteran care.

22.2 Military Culture and Context

It can be argued that the military is a distinct culture, made up of a unique set of values, beliefs, and cultural rules. For example, service to community and country, courage, integrity, and loyalty are among core values. There is also a shared sense of purpose, and a fostering of strong bonds among service members. Service members begin the process of learning about this culture in basic training and become acculturated to various degrees. The degree to which a veteran continues to identify with military culture following separation from the military can influence how mental health symptoms are experienced and reported to the clinician. Hoge (2011) recognized this meeting of cultures by stating that the clinician should meet veterans where they are, literally and figuratively, in terms of culture. Separation from the military and transition back into the civilian setting can be challenging, even apart from stressful or traumatic experiences that may have been experienced while serving.

Recognizing sources of transitional stress in veterans can be an important part of an initial assessment. For example, factors such as whether individuals worked in the civilian sector prior to or after the military, if they are separating, retiring, or remaining connected in a reserve status, whether the separation from the military was planned or involuntary, and how well the job that the veteran had in the military translates to civilian work can all influence the ease of transition from the military context to civilian context. Additionally, military service-related achievements,

experience, and recognition—easily seen on a uniform in medals and ribbons—become "invisible" in the civilian context. Rank and organizational hierarchy, clearly identified and articulated in the military setting, are less evident to the military member and may be difficult to navigate without understanding the unique cues and social norms in a civilian context. Another potential source of transitional stress involves the loss of social support from other service members. Social bonds with other service members can be extremely deep, and the loss of camaraderie and proximity of these relationships can be understandably difficult.

Treatment engagement and rapport with veteran clients can be improved by taking the time to learn about military culture. Unlike many other countries, the USA currently has an all-volunteer military, and those who serve make up a small minority of the population. Thus, civilian providers may not have had exposure to the military and may not have a deep understanding of military culture or context. In countries that require most civilians to serve within some component of the military for a period of time, there may be a deeper sense of connection with the veteran's military experience. Further, veterans vary broadly in their perceptions of their military service. For example, some will perceive their military service positively, whereas others may report more negative experiences and little to no continued positive identification with military culture. Thus, it is important to thoughtfully engage the veteran in conversation about their unique military experience and perceptions of their service. Respect for each individual's experience can be conveyed through sensitively inquiring about the veteran's military experiences such as their role and job, and whether they served in combat or not. Time in session should be dedicated to understanding their overall experience. At the end of this chapter, we provide links to resources that can help the treating clinician become more familiar with key values and beliefs of military culture and logistical and organization aspects of the military.

22.3 Combat Service

> We few, we happy few, we band of brothers. For he to-day that sheds his blood with me, Shall be my brother; be ne'er so vile, This day shall gentle his condition; And gentlemen in England now a-bed, Shall think themselves accurs'd they were not here, And hold their manhoods cheap whiles any speaks, That fought with us upon Saint Crispin's day. – William Shakespeare (Henry V, Act IV, III)

As mentioned previously, there are various types of stressors that a service member may experience, including intense training and deployment experiences. Deployments are not limited to the direct support of combat operations and may include supportive roles well outside of the combat zone as well as humanitarian missions and actions. However, we focus on combat exposure in the next section because of the intense and often profound psychological impact of combat service. Combat stressors may include life-threatening situations, physical injury, witnessing death and dying, experiencing injuries and losses of comrades, and participating in actions that result in the injury or death of another. Additional factors that can

compound these combat stressors include periods of intense action and long work hours interspersed with inactivity and downtime, separation from usual coping mechanisms or support systems, and a loss of control over the situation or environment.

Combat exposure has been associated with higher rates of PTSD, depression, and alcohol misuse (Hoge et al. 2004; Kulka et al. 1990; Kang et al. 2003). Post-deployment PTSD rates were found to vary between 11 and 22 % among veterans of OEF and OIF (Hoge et al. 2004; Seal et al. 2009). Length of deployment and higher level of combat exposure have been found to increase risk for PTSD (Schell and Marshall 2008). Among the many stressors that can be experienced in the combat environment, the consequences of losing comrades and of facing situations which conflict with one's deeply held beliefs and values are profound but often less addressed in traditional treatments for combat-related PTSD.

22.3.1 Grief and Loss

Many veterans who served in combat have experienced the sudden loss of comrades and continue to experience powerful symptoms of grief years later. Studies of US Army soldiers and marines who had deployed to Iraq and Afghanistan found that between 63 and 80 % of those surveyed knew someone who had been seriously injured or killed and 20–25 % experienced having a buddy shot or hit nearby (Thomas et al. 2010; Hoge et al. 2004; Toblin et al. 2012).

Strong bonds formed during training and combat and a sense of responsibility for the well-being of one's comrades can result in losses that deeply impact veterans who have survived combat (Papa et al. 2008). Among one sample of soldiers who had experienced the loss of a comrade, approximately 20 % reported difficulty coping with symptoms of grief (Toblin et al. 2012). In another study of 114 veterans who had served in combat during the Vietnam War, those who reported losses of comrades while serving reported a high level of grief symptoms (Pivar and Field 2004). Strikingly, the authors observed that the level of grief symptoms reported by the veterans was comparable to that endorsed by individuals who had experienced the death of a spouse within the past 3–6 months. Moreover, it was clear that grief symptoms could be distinguished from PTSD and depression symptoms and were most predicted by the losses themselves. Difficulty coping with such losses has also been associated with poorer physical health, occupational functioning, sleep disturbance, fatigue, and pain—including musculoskeletal and back pain and headaches (Toblin et al. 2012). Grief for the loss itself can be complicated by feelings of guilt about surviving when comrades did not or feelings of self-blame related to the belief that the service member or veteran could have prevented the death (Currier and Holland 2012).

In summary, symptoms of grief can remain unresolved, endure for decades (Pivar and Field 2004), and uniquely impact functioning (Toblin et al. 2012). Losses of comrades should be assessed and attended to in the same manner as one would assess traumatic experiences involving the death of a family member or close friend

of a nonveteran client. For more information on the assessment and treatment of traumatic or complex (prolonged) grief, please see Chap. 15.

22.3.2 Moral Injury

Moral injury is a construct that has been increasingly researched during the past decade. It refers to psychological injury resulting from participating in, witnessing, or learning about events during war that violate the service member or veteran's deeply held values or moral beliefs about themselves and humanity (Currier et al. 2013; Litz et al. 2009). The types of experiences that may result in moral injury are broad and include betrayal by leadership or peers, betrayal of one's own values, inability to prevent harm to others, injuring or killing enemy combatants or civilians, witnessing or experiencing atrocities (e.g., inhumane acts), and facing ethical dilemmas (Currier et al. 2013; Stein et al. 2012).

Recent surveys have attempted to quantify the numbers of service members that have been exposed to such situations while serving in Iraq and Afghanistan. Among US Army soldiers and marines who served in Iraq and Afghanistan, 23–32 % reported being responsible for the death of an enemy combatant, 48–60 % reported seeing ill or injured women or children whom they were unable to help, over 50 % reported shooting or directing fire at the enemy, and over 5–9.7 % endorsed being responsible for the death of a noncombatant (Thomas et al. 2010; Hoge et al. 2004). Perception of betrayals from military leaders and of their own personal values, overly harsh treatment of civilians, and guilt about surviving combat were found to be the most endorsed items on a moral injury self-report measure among a sample of veterans who had served in Iraq and/or Afghanistan (Currier et al. 2013).

Studies have found greater PTSD symptoms among veterans who have injured or killed others during their combat service, after accounting for other combat exposure and stressors (Currier et al. 2013; Maguen et al. 2010, 2013; Litz et al. 2009 for review). One study indicated that certain categories of events may be more associated with specific clusters of PTSD symptoms. In this study, morally injurious events committed by self were the best predictor of reexperiencing symptoms, whereas those related to acts of others (such as betrayal or enemy violence) predicted state anger (Stein et al. 2012). Other psychological consequences related to morally injurious experiences include emotional responses, such as guilt and shame, and spiritual or existential concerns (e.g., loss of meaning, struggles with one's religious beliefs; Currier et al. 2013).

Psychological reactions related to morally injurious events such as guilt appear to be more likely to arise following an event versus during it, and it has been suggested that having time to reflect on and process the event may precede the development of some emotional reactions (Stein et al. 2012). The way in which the event is cognitively processed is the core component of the framework for understanding the cause and development of moral injury put forth by Litz et al. (2009). Key to this framework is the thesis that the individual is unable to contextualize or justify their own actions or those of others and that these experiences are not able to be

successfully accommodated into preexisting moral schemas. This conflict then results in emotional responses, such as guilt or shame. Interestingly, a recent study reported that moral injury acts committed by self were related to the guilt-related constructs of *hindsight-bias/responsibility* and *wrongdoing*, but were not related to *lack of justification* (Stein et al. 2012). These findings suggest that service members may be able to understand the underlying rationale and context for their actions and simultaneously experience feelings of guilt.

Although the importance of addressing the impact of these types of experiences has been stressed (Currier et al. 2013), events with moral and ethical implications may not be given sufficient attention during a course of mental health treatment due to both clinician and veteran factors (Litz et al. 2009). Clinicians may not feel prepared to address what can be complex existential and spiritual questions, or they may be focused on other areas of the veteran's experience (e.g., experiences related to life threat). Veterans may hesitate to discuss actions by self or others that are related to feelings of guilt or shame and may be concerned about the potential reaction by the clinician (e.g., rejection, being misunderstood; Litz et al. 2009). Furthermore, some veterans may have fears of legal ramifications for themselves or others. Currier et al. (2013) suggested that these fears may limit the information provided to the clinician in response to questions that are specifically directed at the violation of rules of engagement, participation in atrocities, or other similar types of experiences and thus recommend exploring these topics within the bounds of a broader assessment.

Routinely assessing for these experiences can increase the likelihood that they will come to light and enable them to be addressed during the course of treatment. Such assessment and discussion should be done sensitively and can be guided by recently developed assessment instruments such as the Moral Injury Events Scale (Nash et al. 2013) and the Moral Injury Questionnaire—Military Version (Currier et al. 2013). Whereas clinicians should always provide the space and encouragement for veterans to share traumatic experiences, veterans may wish to share only limited information initially. Clinicians should be sensitive to a veteran's discomfort and allow him or her to determine the pace of any disclosures. Litz et al. (2009) proposed an eight-step treatment to address moral injury. This treatment touches on central components for processing such experiences, including components focused on strengthening the working alliance, providing education, important concerns such as self-forgiveness and social connection, and setting future goals. When appropriate, veterans struggling with spiritual or existential issues related to such experiences may benefit from referral to other services such as those of a chaplain or spiritual leader.

22.3.3 Considerations for Treatment

- Civilian clinicians who have limited experience working with service members or veteran clients may question whether they will be able to connect with or be accepted by the veteran. On the contrary, when speaking with clinicians, they

often report that they are not only able to build strong therapeutic connections but also find the opportunity to serve veterans through providing treatment to be extremely rewarding. There are steps that the clinician can take to strengthen rapport, trust, and engagement in treatment. Analogous to working with other individuals from a different culture, it is important to learn about the military and veteran population. Conveying an interest in and understanding of the aspects of military culture demonstrates respect, can strengthen the therapeutic relationship, and can improve treatment formulation. Whenever possible, treatment providers should seek out training and information to increase their knowledge of military culture.

- In addition to gaining familiarity with military culture, it is essential to set aside stereotypes and assumptions about what it means to be veteran or to serve in combat. As noted earlier in the chapter, there is much variation among the veteran population including differences in reasons for joining the military, how veterans perceive or feel about their service, and their military assignments and experiences.
- In preparing to work with service members and veterans, clinicians should consider conducting a personal assessment of their beliefs and potential limits. For example, will one be able to set aside one's beliefs and judgments about war and politics, and how might one respond to or what is the extent to which one can tolerate themes that may arise in treating combat veterans such as gallows humor or situations involving moral ambiguity (e.g., inadvertently harming civilians in the context of combat)?
- Due to the great variation in experiences among veterans, the importance of a sensitive and comprehensive assessment cannot be overstated. For veterans that have served in combat, factors such as combat operation and era of service as well as individual characteristics such as the veteran's branch of service, job, and rank while serving may all influence the experiences and presentation of the veteran seeking treatment. Providing ample time for the veteran to share his or her personal experience can be critical to inform the direction of treatment. Sensitive experiences, such as those involving grief for fallen comrades and moral ambiguity, can be more difficult to share, accentuating the need to allow adequate time to develop a solid and trusting therapeutic relationship.
- The need for multidisciplinary care should be recognized. Veterans should be screened not only for comorbid mental health conditions but also comorbid physical health conditions and referred appropriately. For example, the physical demands of military service (e.g., physical training, combat injuries) can lead to chronic pain. Among a sample of 1,800 veterans who served in Afghanistan and Iraq, 46.5 % reported some pain, with 59 % of those exceeding a clinical threshold of greater than or equal to 4 (0–10 scale; Gironda et al. 2006). Both PTSD and chronic pain tax the coping resources of veterans, which can exacerbate both conditions and can negatively impact functioning and quality of life (Clapp et al. 2010; Sharp and Harvey 2001). Other physical injuries, such as traumatic brain injury, can also profoundly impact recovery.

- As stated above, combat veterans may present with a complex set of conditions including PTSD, pain, and sleep problems, which may feel overwhelming for the clinician to address. Awareness of one's own limits of clinical expertise and knowledge of where one might seek additional resources and support (e.g., consultation, supervision, referral for additional services) can be important to both the clinician and the overall success of treatment.

Case Illustration: Luis, Male, Operation Enduring Freedom (OEF) Combat Veteran

Luis joined the military at 18 years of age after graduating from high school. He had looked forward to serving in the military as both his father and grandfather had enlisted in the military. He served two tours in Afghanistan during which he engaged in many firefights, both receiving fire and firing at enemy combatants. During his second tour in Afghanistan, he experienced a blast caused by an improvised explosive device (IED). This same blast resulted in the death of one of his comrades.

Upon separation from the military, Luis decided to use the educational benefits he had earned through serving in the military to go to college. He was unprepared for the feelings of anxiety that struck him when he stepped onto the campus. He found that certain class material and comments by teachers or other students about the war brought up vivid memories of his experiences in Afghanistan, and he would find himself unable to concentrate for the rest of the day. He felt unable to connect with civilian students, and he spent much of his time on campus in the Veterans Resource Center where he met and engaged with other veterans. Luis felt that he should have been able to deal with his feelings, "just suck it up," as he had been able to do with many difficult experiences while serving, but no matter what he did, he found that the thoughts and images kept returning.

Luis started to wonder why, after separating from the military, things seemed to be getting worse, not better as he expected. He had looked forward to being home and to returning to his civilian life. While at his primary care appointment, his doctor conducted a number of mental health screenings, and Luis screened positive for PTSD. His doctor spoke with him about the symptoms, gave him information on websites that provided educational material, and suggested a referral to a mental health provider. Luis said he would think about it and took the information. That night he went home and looked up PTSD online, where he read about the symptoms and treatments, and noticed that other veterans were sharing similar stories and experiences to his own. Although ambivalent, he decided to call the number that was provided to him and set up an appointment to see a psychologist with experience in treating PTSD.

As Luis drove up to the clinic, he became anxious and had a strong urge to turn the car around and go home. His mind was racing with thoughts like, "Is

it worth digging up all this stuff?" "What will a civilian know about any of this anyway?" "Will he/she judge me?" "I should be able to deal with this myself." Only halfway through the school semester, he was not sure he would be able to keep up his grades and maintain his GI Bill eligibility while taking medications that might "mess with" his mind. Still, he did not want to "no show" to his appointment, so he parked and checked in at the front desk, determined to avoid any medications that this doctor might give him.

Dr. Keast greeted Luis warmly, inviting him into the office. Although she had never served in the military, Dr. Keast had sought out information about military culture and consulted with colleagues to increase her knowledge. She asked how Luis felt about coming in, acknowledging that it can be difficult to ask for help, introduced herself and her professional background and expertise, noting that while she had not served in the military herself that she greatly appreciated his service and looked forward to working with him. Dr. Keast then provided him with an agenda for the session. She outlined that she would ask some general questions about his background, current living situation, military experience, and current symptoms—and that he was welcome to decline to answer anything he was uncomfortable with answering or discussing. She inquired about when, where, and in what role Luis had served, and she allowed him time to share and ask questions. Dr. Keast normalized the difficulties of transitioning out of the military. She also noted how certain behaviors, such as the ability to function on limited or inconsistent sleep schedules and remaining aware and prepared (hypervigilance), can be adaptive while in combat but may be inconsistent with life in the civilian context. In the course of the assessment, she learned that Luis was struggling with the meaning behind his service because of some of the things that he had witnessed while at the same time continuing to feel deeply connected to and proud of his military service. Dr. Keast normalized these experiences, providing information about moral injury to Luis and encouraging him to continue to discuss these issues in treatment. Dr. Keast inquired about blast injuries and learned that he had suffered a concussion following his exposure to the IED blast. She received his permission to refer him to a cognitive rehabilitation specialist for an assessment.

Luis decided to engage in a time-limited course of prolonged exposure therapy (PE) which allowed him to discuss his experiences and process through them, as well as to approach situations that he had been avoiding. After treatment, he continued to report residual symptoms of sleep disturbance for which Dr. Keast referred him to a sleep specialist for a course of cognitive behavioral therapy for insomnia. Dr. Keast also connected Luis with on-campus disability services so that he could receive accommodations, such as extended test-taking time and access to a notetaker, in the classroom for difficulties with concentration and anxiety symptoms. Luis began to feel more confident in his academic work, to engage in social activities again, and to feel more hopeful for the future.

22.4 Military Sexual Harassment and Assault

While serving in the military comes with the obvious risks to life and limb associated with combat exposure, too often sexual harassment and sexual assault are also a part of service members' military experiences. Sexual harassment is generally defined as unwanted sexual experiences that occur in the workplace and may include an array of behaviors, including offensive sexual comments, display of pornographic materials, promises of punishment or rewards related to performance of sexual favors, and sexual assault. Sexual assault is generally defined as unwanted physical sexual contact that includes a range of behaviors from unwanted touching of a sexual nature to nonconsensual vaginal, anal, or oral penetration (rape). Within VA, military sexual trauma is specifically defined as, "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or [on] active duty for training" (US Code 1720D of Title 38).

There are some unique factors that contribute to the complexity of sexual harassment and assault in the military (Turchik and Wilson 2010). A key factor is the strong masculine orientation associated with military culture that reinforces strength and control. With women a clear minority in the active duty service (approximately 20 % of the force), inappropriate conversations and activities can easily develop that ultimately lead to an environment that condones sexual harassment and even sexual assault. Additionally, victims (either male or female) can be reluctant to report abuse as they may be seen as weak by other service members in the organization—either for contributing to the incident or not being able to stop it. Another important factor is the significance of rank structure and unit cohesion in the military. While these are valuable characteristics to accomplish a specific mission, they can also increase the vulnerability of lower-ranking service members and make the decision to report the incident that much more difficult if it occurs within the same unit.

22.4.1 Prevalence

It is difficult to determine the actual prevalence and incidence of sexual harassment and sexual assault in the military due to a number of factors (i.e., inconsistency in definitions across studies, underreporting); however, research suggests that it is not uncommon. In the 2006 Department of Defense (DoD) Workplace and Gender Relations Survey of Active Duty Members (Lipari et al. 2008), the annual prevalence of sexual assault was 6.8 % for women and 1.8 % for men. Rates were 9.0 and 3.0 % for women and men, respectively, for sexual coercion and 31.0 and 7.0 %, respectively, for unwanted sexual attention. It is important to note that while a higher percentage of women than men experience sexual assault/harassment during their military service, the actual numbers of women and men who experience military sexual assault/harassment are similar given the higher percentage of men in the military.

22.4.2 Mental Health Consequences

Research has demonstrated that veterans who report sexual trauma during military service are at greater risk for a number of physical health problems (Frayne et al. 1999; Kimerling et al. 2007; Turchik et al. 2012), mental health problems (Kimerling et al. 2007, 2010), and other impairments in functioning (Skinner et al. 2000), even years after the stressful experience. Research has found increased rates of mental health problems, including posttraumatic stress disorder (PTSD), depression, anxiety, substance use disorders, and sexual dysfunctions, among those who experienced sexual trauma during military service (e.g., Kimerling et al. 2007; Turchik et al. 2012). The condition that appears to be most highly associated with military sexual trauma is PTSD (e.g., Kimerling et al. 2007). This is consistent with other research which has found that rape leads to a higher risk of PTSD than any other trauma, including combat, in both veteran and nonveteran samples (Kang et al. 2005; Kessler et al. 1995; Yaeger et al. 2006).

22.4.3 Considerations for Treatment

- Many of the empirically supported PTSD treatments, including cognitive processing therapy (CPT; Resick and Schnicke 1993) and prolonged exposure (PE; Foa et al. 2007), were initially developed for and tested with sexual assault survivors, and these treatments have been shown to be helpful for those with sexual trauma-related PTSD. However, it should be noted that these treatments have primarily been tested with female sexual assault survivors, and further research may be needed for male sexual assault survivors. Additional PTSD treatments (e.g., skills training in affective and interpersonal regulation narrative therapy, STAIR; Cloitre et al. 2006, acceptance and commitment therapy, ACT; Walser et al. 2013) are also available and are being used with veterans who have experienced sexual trauma.
- Given that the sexual violence occurred within the military, the context may present additional concerns for victims. Providers should be attuned to confidentiality issues, stigma, concerns about effects on their job, perpetration retaliation, unit cohesion, and other issues that may be qualitatively different than for someone who experienced sexual trauma as a civilian.
- Given the gendered nature of sexual trauma, it is also important to ensure that screening and treatment is delivered in a gender-sensitive manner. If seeking care within the military or at Veteran Medical Centers, both men and women in particular may face barriers related to being immersed in and receiving care in a male-dominated environment. The gender of the provider should also be taken into consideration. Two qualitative studies have examined whether veterans who have experienced military sexual trauma have a provider gender preference in regard to seeking care related to their military sexual trauma experience (Turchik et al. 2014, 2013). These results found that the majority of men and women did have a preference, with women with a preference preferring a female provider

and men being more mixed in their preferences. Such findings suggest that asking sexual assault survivors whether they have a preference and honoring this preference when possible may better facilitate ensuring that these veterans receive the treatment they are seeking.

- It is important for providers to recognize that while an experience of a sexual trauma increases the risk for mental health problems, it is not a diagnosis and not all men and women who experience sexual trauma will want or need to seek treatment. Further, while PTSD is one of the most common diagnoses associated with sexual trauma, providers should be mindful that there are a number of other mental and physical health issues associated with sexual victimization.

Case Illustration: Janine, Female, Military Sexual Assault Survivor

Janine is a 35-year-old woman who experienced a recent sexual assault by an officer in her unit during her first assignment following boot camp. After the attack, the officer continued to make lewd comments and gestures, grab her inappropriately, and threaten to enter her bunk at night. When Janine attempted to describe her experience to some of her peers, she was told to "get over it" and "not make a big deal." She hesitated to report his behavior for fear of jeopardizing her military career and losing her friends who were also close with the perpetrator. While on active duty, Janine made every attempt to not think about the experiences by distracting herself with her work and telling herself she was "overreacting." However, after leaving the military, Janine's symptoms, including insomnia and hypervigilance, worsened. She insisted on sleeping with a gun under her pillow, and she avoided going out with friends because she "didn't trust men anymore" and feared that her male friends would attempt to make unwanted sexual advances.

Due to an inability to sleep, Janine could not hold a job and feared she would never be able to work again. After building a tolerance to over-the-counter sleep medications, Janine sought out a primary care physician, who she hoped would prescribe a stronger sleeping pill. During her visit, Dr. DuBois completed a military sexual trauma screening. Janine confided in her doctor that she had experienced military sexual trauma and was having nightmares involving her perpetrator. Seeing her distress, Dr. DuBois informed Janine of the treatment options available and provided her with a number to contact to set up an appointment with a psychologist with PTSD treatment experience.

Janine was embarrassed that she had never sought treatment before, even though she knew it probably would have helped. With several different job assignments and her self-imposed busy schedule, she had never taken the time to look up the number to the mental health clinic. She also wished that she had the courage to report the incident when it happened, instead of keeping it quiet. If she knew then how this was going to impact her, she could have found the right person to tell; she was pretty sure that the same perpetrator had

assaulted other people after her. She really did not want to get caught up in an investigation or to have to testify against that officer; thankfully she had not seen him since her first assignment. However, she was not sure if the psychologist would need to make a formal report to the military police if she told too many details. With all of those conflicting thoughts and swirling emotions, Janine made an appointment. Without a job, she figured she had the time to deal with this now.

After an initial assessment, it was decided by Janine and her psychologist that cognitive processing therapy would be a good treatment to try. It was clear that Janine had developed a lot of self-blame related to the harassment and that she felt that she must have "led [him] on" or done something to warrant the harassment. She described believing not only that she could no longer trust men but that she was now "dirty" and "worthless" and that she did not "deserve a good man anyway." Janine described her fears that she would never get back to normal and that she was permanently damaged. Her therapist focused on examining and challenging the beliefs and thoughts that were impacting Janine's recovery. This included completing assignments to explore Janine's perception of events and tendency to self-blame. She also addressed Janine's insomnia by psychoeducation on sleep hygiene and a referral to a sleep specialist. Writing an account of the trauma and processing through this account during the course of therapy helped Janine to make sense of the events she has been adamantly avoiding and allowed her to feel the emotions associated with her harassment. By the end of treatment, Janine showed significant improvement in sleep duration and sleep quality, reduction of nightmares, and willingness to engage in coed social activities. She also showed significant decreases in her PTSD symptoms and no longer felt the need to check her locks or look over her shoulder constantly. She also expressed increased self-efficacy and is currently in the process of seeking employment. Janine also finally began to feel open to the possibility of a romantic relationship in the future. Even after the end of treatment, she continues to read back over her therapy materials and complete therapy worksheets when she feels "stuck" about something.

22.5 Summary and General Treatment Considerations

It is not within the scope of this chapter to fully cover the many different clinical presentations and issues that may arise in the clinical setting. The veteran population is incredibly diverse, spanning generations, ethnicity, and gender. Many veterans have served during war, and many others have served during times of peace; still others have served on humanitarian missions around the globe. Thus, the importance of listening to the unique narrative with which each veteran presents is emphasized and recommendations are offered within this chapter to provide some general guidance when treating veterans with PTSD.

22.5.1 Barriers to Seeking Mental Health Care

A significant number of veterans who are in need of mental health care for PTSD do not seek out services (Shiner 2011). A 2003 survey of US soldiers and marines who served in combat found that despite up to 17.1 % endorsing the presence of a mental illness, only 23–40 % of those who screened positive sought mental health care (Hoge et al. 2004). In another national random sample of OEF and OIF veterans, 20 % screened positive for probable PTSD (Elbogen et al. 2013). Among those, greater than two-thirds had sought mental health treatment. Studies have documented a number of barriers to seeking mental health care, including concerns about and readiness for mental health treatment (Stecker et al. 2013), stigma surrounding the ramifications of seeking treatment on one's future military career and self-stigma such as perceiving mental health treatment as a sign of weakness (Hoge et al. 2004; Stecker et al. 2007, 2013), and logistical barriers such as scheduling, distance from health care, and balancing multiple roles (e.g., employee, student, and parent) (Hoge et al. 2004; Stecker et al. 2013). Interestingly, among a sample of service members that had served in Iraq and Afghanistan, the most endorsed barriers to care included concerns about treatment such as limited choices for treatment (i.e., medication would be prescribed; preferences for individual versus group treatment), concerns that one's situation would not be understood by a mental health clinician (e.g., only those who had been deployed to war would understand), and the perception that treatment was not needed or that one was not ready for treatment (Stecker et al. 2013). Believing one should solve one's own problems was more often endorsed among veterans with probable PTSD who did not seek mental health treatment (Elbogen et al. 2013). Given these various barriers to care, provision of mental health treatment may be improved through consideration of the following:

- Outreach to veterans in the community is warranted in order to raise awareness for veterans with PTSD who do not readily seek out treatment. Provision of education about PTSD and availability of services in places outside traditional arenas of care (e.g., college campuses, veteran's organizations) may increase the likelihood that some veterans will seek and receive care.
- Successful retention in treatment relies on the establishment of a solid and trusting therapeutic alliance between client and provider. A provider's understanding of military culture can bridge the civilian-military divide, increasing the veteran's sense of being understood and trust in the competence of the provider. For providers with limited contact with military or veteran populations, gaining education in military culture can increase sensitivity to the unique experience of each veteran, and it can enhance the clinician's ability to appropriately screen for military history while also guiding treatment formulation.
- Cultural factors can influence how mental illness and treatment for mental illness are perceived. For example, during military service, strength, endurance, and the ability to solve problems quickly are highly valued characteristics. Mental illness may be perceived as a weakness, and this can lead to ambivalence about seeking

mental health care. Providing clear and direct education to the veteran about PTSD, treatment options, and what to expect during the course of treatment as well as allowing adequate time to answer any questions that arise can demystify mental health treatment and build confidence regarding potential helpfulness.

22.5.2 Assessment and Treatment

A comprehensive assessment should be completed prior to beginning treatment. Such an assessment should include information about military background and experience, and it should also elicit information about PTSD-related conditions and functioning, such as those discussed earlier. Co-occurring psychological and physical conditions should also be included in the assessment. During the recent wars in Iraq and Afghanistan, the use of improvised explosive devices (IEDs) by the enemy and increased survival rates for veterans with severe injuries due to better protective gear and medical care have led to an increase in particular comorbidities. Co-occurring PTSD, pain, and traumatic brain injury, resulting from these types of events, have been deemed "signature wounds" of combat. Assessing for these physical and functional concerns and connecting the veteran with appropriate specialty care is extremely important. For example, offering a referral to a pain or cognitive rehabilitation specialist should be done in conjunction with providing psychotherapy for PTSD.

Recent studies support the use of trauma-focused therapies such as CPT (Resick and Schnicke 1993) and PE (Foa et al. 2007) for veterans (Department of Veterans Affairs and Department of Defense 2010). Acceptance and commitment therapy (ACT) has also been shown to reduce symptoms of depression and anxiety in veterans (e.g., Walser et al. 2013). For veterans with complex presentations (e.g., multiple traumas, emotional regulation deficits), stage-based treatments such as skills training in affective and interpersonal regulation narrative therapy (STAIR; Cloitre et al. 2006) and dialectical behavior therapy (DBT; Linehan 1993) may be considered (Landes et al. 2013).

In addition to individual psychotherapy, both family and peer support interventions can be important modes of treatment for those who are ambivalent about receiving mental health care. Family members can be deeply affected by their loved one's mental illness, and they often play a key role in recovery. Specific interpersonal disturbances reported by veterans with PTSD include worse family relationships (Koenen et al. 2008), difficulties in intimacy and communication, and higher rates of separation and divorce (Riggs et al. 1998; Cook et al. 2004). Among a sample of US Army National Guard soldiers, family counseling was an appealing option to the majority of those surveyed (Khaylis et al. 2011). Peer outreach and support has also shown promise in enhancing access to and engagement in treatment for individuals with PTSD (Jain et al. 2013). Given the often unique bond that exists between veterans, the integration of peers into the treatment plan should be considered.

22.5.3 Online Resources

In recent years, a number of resources for providers have been developed to facilitate a deeper understanding of military culture and to support mental health treatment. The Community Provider Toolkit (http://www.mentalhealth.va.gov/communityproviders/) provides information on understanding the military experience, mental health and wellness, and available resources. The Center for Deployment Psychology, funded in part by the US Department of Defense, provides additional information and trainings for clinicians working with military service members (http://deploymentpsych.org/). The National Center for PTSD website provides extensive education on the assessment and treatment of PTSD for veterans including a searchable database, PILOTS, that is regularly updated (http://www.ptsd.va.gov/).

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