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Post-Traumatic Stress Disorder (PTSD) in the Armed Forces: Diagnosis, Treatment, and Prevention

Ioan Emanuel Ropan
Lieutenant
22nd "Romanați" Infantry Battalion,
Multinational Brigade South-East Craiova,
Ministry of National Defense, Romania
E-mail: emanuelropan07@yahoo.com

Abstract

Post-traumatic stress disorder (PTSD) is a common problem among military personnel and veterans, affecting between 8% and 25% of those exposed to combat. This article analyzes, in the form of a theoretical and clinical synthesis, the diagnostic criteria according to the DSM-5, empirically validated treatment modalities, and prevention strategies specific to the military context. About 73% of veterans respond positively to trauma-centered psychotherapeutic approaches, such as Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT), while SSRI (Selective Serotonin Reuptake Inhibitors) medications reduce the risk of relapse by 80%. The paper also highlights the importance of prevention models (primary, secondary, and tertiary), underlining the significant role of military social work in supporting affected personnel and their families. This multidisciplinary structure acts as an essential psychosocial buffer, facilitating case management, systemic support for service members, veterans, and their families, as well as post-mission reintegration.

Keywords: combat, diagnosis, military social work, prevention, PTSD, treatment, veteran.

1. INTRODUCTION

Service members and veterans frequently encounter traumatic experiences that can severely impact their mental health. Post-Traumatic Stress Disorder, commonly known as PTSD, develops following exposure to extreme events, such as combat operations, terrorist

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attacks, or severe accidents. This condition is not a sign of weakness, but rather a normal reaction of the human body to abnormal situations. Understanding PTSD is essential for military social workers, whose primary role is to support personnel and their families during difficult times.

International epidemiological studies reveal significant variations in PTSD prevalence, depending on the specific characteristics of the armed forces and their level of risk exposure:

- **Ethiopia:** affects approximately 22% of service members;
- **United States:** affects up to 25% of veterans exposed to combat;
- **United Kingdom:** affects 18% of service members wounded in combat;
- **Canada:** registers a rate of approximately 8% among military personnel

(Tedla et al., 2024; VA, n.d.).

These statistical disparities can be explained by the specific ways each military institution prepares its soldiers and supports them post-deployment. By comparison, within the general population, only about 6% of individuals develop PTSD during their lifetime, which clearly demonstrates the increased vulnerability generated by the military environment (Goldstein et al., 2016).

1.1. Research Hypotheses

Based on the specialized literature, the following working hypotheses were formulated:

- PTSD is more prevalent among service members exposed to combat compared to the general population;
- Trauma-focused cognitive-behavioral therapies exhibit high efficacy in reducing PTSD symptomatology;
- Pharmacotherapy based on selective serotonin reuptake inhibitors (SSRIs) contributes significantly to symptom reduction;
- Resilience-based prevention programs show limited effects and require further improvement;
- Military social work plays a critical role in the recovery of affected personnel, serving as an indispensable pillar in case management.

2. METHODOLOGY

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The present paper is a narrative review of the literature, conducted through a critical analysis of scientific articles published in indexed international journals. The documentation process involved querying reference databases such as PubMed, PsycINFO, and the Cochrane Library, alongside consulting official reports published by the US Department of Defense (DoD) and the Department of Veterans Affairs (VA).

Studies published within the last 15 years addressing the specific diagnosis, prevention, and treatment of PTSD in the military context were selected. No primary field research or interviews were conducted; all information originates from peer-reviewed, previously published sources.

3. RESULTS AND DISCUSSION

3.1. Understanding PTSD and Its Identification: Clinical Presentation and Diagnostic Criteria according to the DSM-5

PTSD is a disorder that develops following exposure to a major trauma. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), used by clinicians and researchers worldwide, classifies the specific manifestations of this condition into four major symptom clusters:

- **Intrusion or re-experiencing:** the individual relives the traumatic event through nightmares, distressing memories, or flashbacks;
- **Avoidance:** the individual avoids places, people, or situations associated with the traumatic event;
- **Negative alterations in cognitions and mood:** feelings of guilt, profound sadness, or a loss of interest in previously enjoyed activities;
- **Hyperarousal and reactivity:** a state of constant alertness, disturbed sleep, irritability, and concentration difficulties.

Guina et al. (2016) point out that the modifications introduced by the DSM-5 in 2013 substantially altered the perspective on diagnosing PTSD. For instance, the requirement for an immediate emotional reaction (such as fear or helplessness) is no longer mandatory. Furthermore, indirect exposure to trauma, such as viewing graphic images from an attack scene, can now be taken into consideration. These changes have practical implications for

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service members, as the diagnosis influences both clinical treatment and eligibility for veteran benefits (p. 1).

3.2. Who is at Risk of Developing PTSD? Risk Factors and Resilience Predictors

Not all service members who experience traumatic events go on to develop PTSD. Risk factors identified in the literature include: female biological sex (women appear to be more vulnerable), direct combat participation, handling human remains, a high number of deployments (especially exceeding four), low individual resilience, lack of social support, and the co-occurrence of depression. A study conducted at a military hospital in Ethiopia showed that 22% of admitted service members met the criteria for PTSD; those with extreme combat exposure faced a risk nearly five times higher of developing the disorder compared to non-exposed personnel (Tedla et al., 2024).

Conversely, protective factors also play a major role. Pietrzak et al. (2010) demonstrated that psychological resilience and post-deployment social support protect against the onset of PTSD. Soldiers who have someone to rely on, and who receive active help from their families and communities, have a significantly higher chance of recovery without developing a chronic disorder. These findings underscore the crucial importance of social work within the military environment (p. 188).

3.3. PTSD Treatment: Psychotherapy versus Pharmacotherapy

PTSD treatment is broadly divided into two main categories: psychotherapy and pharmacotherapy. International clinical guidelines, such as the VA/DoD Clinical Practice Guideline (2017), recommend three types of psychotherapy as first-line treatments: Prolonged Exposure (PE) therapy, Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). These modalities have been rigorously tested across numerous studies and have proven effective in reducing symptoms for the majority of patients.

The largest comparative study to date was published by Sloan et al. (2022) in *JAMA Network Open*. The researchers compared PE and CPT among 916 American veterans across 17 medical centers. The results indicated that both therapies are highly effective, though PE demonstrated slightly better outcomes. Approximately 73% of participants in the PE group responded positively to treatment, compared to 66% in the CPT group. Furthermore, 40% of

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those treated with PE no longer met the diagnostic criteria for PTSD, compared to 32% in the CPT group. However, this difference was not statistically significant enough to declare one treatment definitively superior to the other. The authors concluded that the choice of therapy should ultimately align with patient preference.

Clinical Success Indicator	**Prolonged Exposure Therapy (PE)**	**Cognitive Processing Therapy (CPT)**
Positive treatment response rate	73%	66%
Full PTSD diagnostic remission rate	40%	32%

A major challenge highlighted by the study was the high dropout rate, as more than half of the participants discontinued treatment prematurely: 56% in the PE condition and 47% in the CPT condition. This emphasizes the urgent need for enhanced support systems to help service members remain engaged throughout the therapeutic process.

From a pharmacological perspective, the most widely utilized treatments are selective serotonin reuptake inhibitors (SSRIs), specifically sertraline and paroxetine. These medications are prioritized by the VA/DoD guidelines. Marshall et al. (2001) demonstrated that paroxetine significantly reduces symptoms of avoidance, hyperarousal, and re-experiencing in patients with chronic PTSD. In their study, 62% of those treated with paroxetine responded positively, compared to only 32% in the placebo group (p. 1982). Similarly, Davidson et al. (2001) showed that sertraline is highly effective in preventing relapse: only 5% of patients who continued sertraline treatment experienced a relapse, compared to 26% of those switched to a placebo. This represents an approximate 80% reduction in relapse risk (p. 1974).

3.4. PTSD Prevention: Resilience Programs

Preventing PTSD has become a primary objective for modern armed forces. In the United States, large-scale programs such as *Battlemind* and *Comprehensive Soldier Fitness* (CSF) have been implemented. *Battlemind* was designed as a post-deployment training program to help soldiers process their experiences and transition smoothly back into civilian

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life. While initial evaluations were promising, subsequent studies yielded mixed results. Adler et al. (2008) found that psychological group debriefing—a key component of *Battlemind*—does not reduce PTSD symptoms and may even exacerbate them in certain individuals (p. 253).

The *Comprehensive Soldier Fitness* (CSF) program, launched in 2009, stands as the most ambitious initiative of its kind, reaching over one million soldiers. The program incorporates resilience training, online learning modules, and periodic assessments. Nonetheless, the Institute of Medicine (2012), a prestigious US institution, critically evaluated the initiative and concluded that clear empirical evidence demonstrating that CSF prevents or reduces PTSD is lacking. The official report states that *"none of the DoD and VA programs have demonstrated evidence of effectiveness in preventing PTSD"* (Institute of Medicine, 2012, p. 97). This finding serves as an important cautionary note: prevention programs must be rigorously tested before being deployed at a systemic scale.

3.5. The Role of Military Social Work in Integrated Case Management

Military social workers hold a central role in the systemic management of PTSD. Rubin, Weiss, and Coll (2013), in the *Handbook of Military Social Work*, outline their core competencies: comprehensive knowledge of war-related trauma, a deep understanding of PTSD symptoms, familiarity with suicide prevention protocols, and the ability to coordinate care across multiple institutional boundaries. Social workers are frequently the first professionals to interface with a struggling service member or their family, positioning them uniquely to identify early warning signs of the disorder.

A concrete example of best practice is found within the US Army's Combat Stress Control (CSC) teams. These teams—composed of psychologists, psychiatrists, and social workers—operate directly within operational theaters to provide immediate psychological first aid to soldiers in distress. They conduct informational briefings, hold informal discussions with troops, and intervene rapidly during crises. The guiding principle is that assistance must be provided as close to the soldier as possible, as quickly as possible, and as simply as possible. This model could be highly translatable to the Romanian military context, where social workers can become an essential pillar of the institutional mental health infrastructure (Institute of Medicine, 2012, pp. 5-7).

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3.6. Limitations of the Study

The current review paper has several methodological and conceptual limitations that must be considered when interpreting its conclusions:

- The paper does not rely on primary empirical research (such as field interviews, surveys, or original clinical trials) but is rather a narrative review of existing literature. Consequently, the validity of these findings is closely tied to the accuracy and methodological rigor of the reviewed studies;
- The overwhelming majority of the specialized literature and validated clinical guidelines (e.g., VA/DoD, Sloan et al., 2022) originate from the Anglo-Saxon space, particularly the United States;
- The direct generalizability of these models to the Romanian Armed Forces may be constrained by significant cultural, budgetary, structural, and institutional value system differences;
- There is a pronounced shortage of recent clinical and epidemiological studies published in international databases regarding PTSD incidence and case management among Romanian service members returning from international missions;
- The documentation and analysis process was strictly limited to studies published in Romanian and English within the last 15 years, leaving open the possibility that relevant research published in other languages or restricted institutional reports was omitted.

4. CONCLUSIONS

The analysis of the specialized literature highlights that post-traumatic stress disorder remains a military public health issue of undeniable severity, affecting approximately 22% to 25% of personnel exposed to combat. Nevertheless, the clinical prognosis is significantly improved by the existence of highly effective therapeutic protocols: approximately 73% of veterans respond positively to cognitive-behavioral therapies (PE, CPT), and SSRI medications reduce relapse rates by roughly 80%.

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Regarding prevention, resilience programs like *Comprehensive Soldier Fitness* have not yet demonstrated their intended efficacy and require further empirical evaluation.

Military social work plays an essential role across all stages of care: from the early identification of symptoms to treatment coordination and the long-term psychosocial reintegration of veterans. Social workers can contribute significantly to reducing the stigma surrounding mental health issues within the military, fostering a climate of trust where service members feel safe seeking help without fear of professional repercussions.

Looking forward, it is imperative to develop empirical studies tailored specifically to the cultural and institutional context of the Romanian Armed Forces, implement culturally optimized prevention programs, and increase investment in specialized trauma and psychosocial rehabilitation training for military social workers.

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