Treating PTSD During Ongoing War: Real-Time Symptom Trajectories and Functional Reintegration in Active-Duty Soldiers

Clinical Insights from the Ta'atzumot Clinic for Soldiers with Post-Traumatic Symptoms

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IDF Medical Corps

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SESSION

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Emerging Psychological Health Threats in Large-Scale Combat Operations

Disclosures and clearance

✓ Conflict of interest

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Organizational clearance

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Contributors and acknowledgements

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- **COL Jacob Rothschild, MD**
- **BG Zivan Aviad-Beer, MD**

We are especially grateful to the soldiers who participated in treatment and contributed their outcome data.

The challenge after large-scale combat

Symptoms do not end when the acute event ends.

Intrusions

Nightmares, flashbacks, and persistent re-experiencing

Hyperarousal

Sleep disruption, irritability, anger, and constant threat perception

Avoidance & withdrawal

Disconnection from the unit, family, and daily roles

Comorbidity

Depression, anxiety, substance use, and functional decline

The clinical problem is not only symptom reduction — it is preventing chronic disability and restoring meaningful function

A continuum of military mental health care

Ta’atzumot fills the gap between acute response and long-term rehabilitation.

Clinical insight: maintaining continuity with the unit and command structure can be therapeutic

Ta’atzumot at a glance

A purpose-built military PTSD treatment and rehabilitation center

May 30, 2024

Established

1,600

soldiers treated to date

≈220

patients in care at any time

3

treatment pathways

Scale required standardization, measurement, and a rehabilitation model that could operate within the military system.

Three treatment pathways

Intensity is matched to impairment, clinical need, and functional goals.

Intensive day program

3 weeks

Organic cohort • mandatory daily schedule • group and individual treatment • strong command involvement

Enhanced outpatient track

Up to 6 weeks

Higher-frequency care for soldiers needing stabilization and a structured bridge to reassignment or return to duty

Outpatient track

≈3 months

Weekly individual psychotherapy with ongoing measurement and coordination with the military system

All pathways share one objective: symptom improvement alongside restoration of function and meaningful military participation

What we do differently

Cohort as a source of strength

Shared experience reduces isolation and enables mutual accountability.

Visible command involvement

Commanders help maintain belonging, continuity, and realistic return-to-service planning.

Functional activation

Daily structure and graded responsibility counter avoidance and passivity.

Trauma-focused, time-limited care

Evidence-based treatment is delivered within a clear rehabilitation frame.

Body–mind integration

Physical activity, yoga, breathing, and regulation skills are embedded in care.

Meaning and flexibility

Treatment is adapted to the soldier while preserving purpose, discipline, and expectations.

Inside the intensive track

A three-week structured rehabilitation experience.

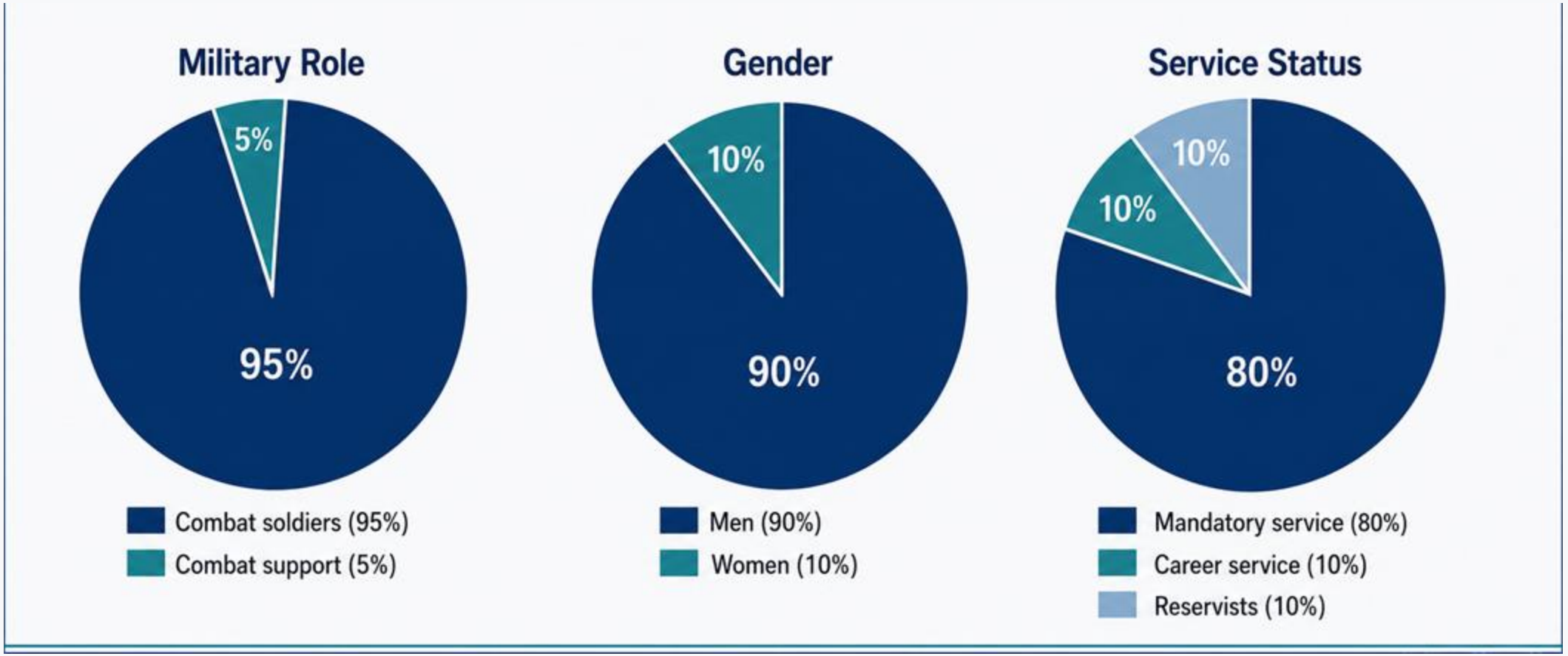
A typical day combines

- Trauma-focused group therapy
- Individual psychotherapy
- Physical activity and somatic regulation
- Psychoeducation and skills practice
- Rehabilitation planning

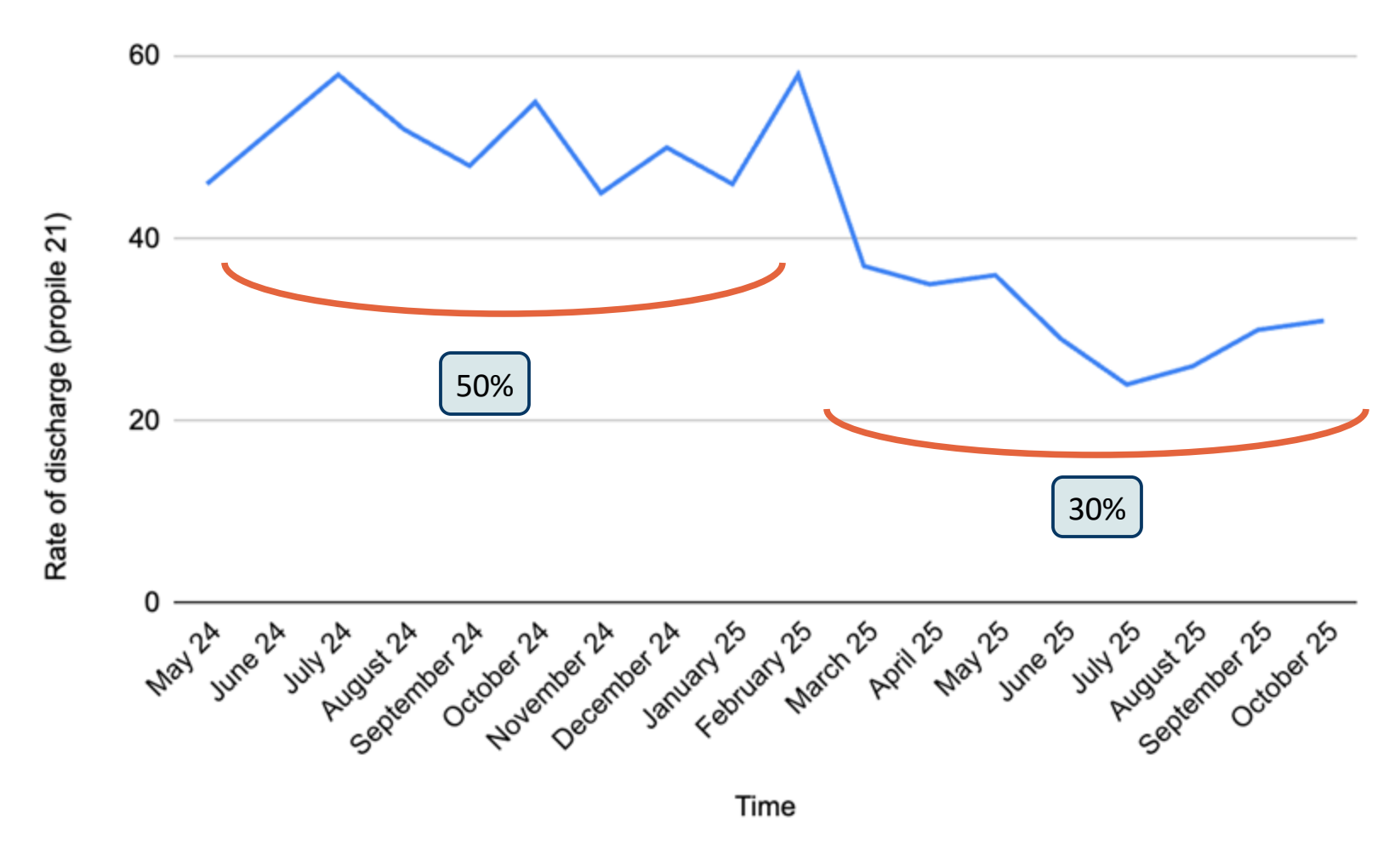
The schedule is deliberately demanding: participation itself is a graded return to structure, agency, and social connection

Participant Characteristics

A three-week structured rehabilitation experience.



Rehabilitation and reintegration change the endpoint



Treatment success is measured in function, not only symptom scores.

≈70% continued to serve after implementation

Measurement is built into care

Routine outcomes support clinical decisions and continuous learning

Baseline	6 weeks	3 months	6 months	12 months
n=775	n=321	n=256	n=254	n=307

The analyzed sample reflects the dataset available at the time of statistical analysis. The live clinical database now contains over 1400 questionnaires and continues to grow

Routine outcome measurement battery

Validated symptom scales are combined with functional, social, military, and treatment-process measures

TRAUMA & PTSD

Criterion A exposure screen
PCL-5 · PTSD symptom severity

ANXIETY & DEPRESSION

GAD-7 · anxiety
PHQ-9 / PHQ-8 · depressive symptoms

FUNCTION & SOCIAL SUPPORT

POAMS-TV · functioning
Perceived support from family, friends, and significant others

MORAL INJURY & MILITARY EXPERIENCE

MIES · potentially morally injurious events
EMIS-SF · military experience and moral injury outcomes

TREATMENT EXPERIENCE

CSQ-8 · treatment satisfaction
Continued care, use of learned regulation skills, and group contact

HEALTH BEHAVIOR & REINTEGRATION

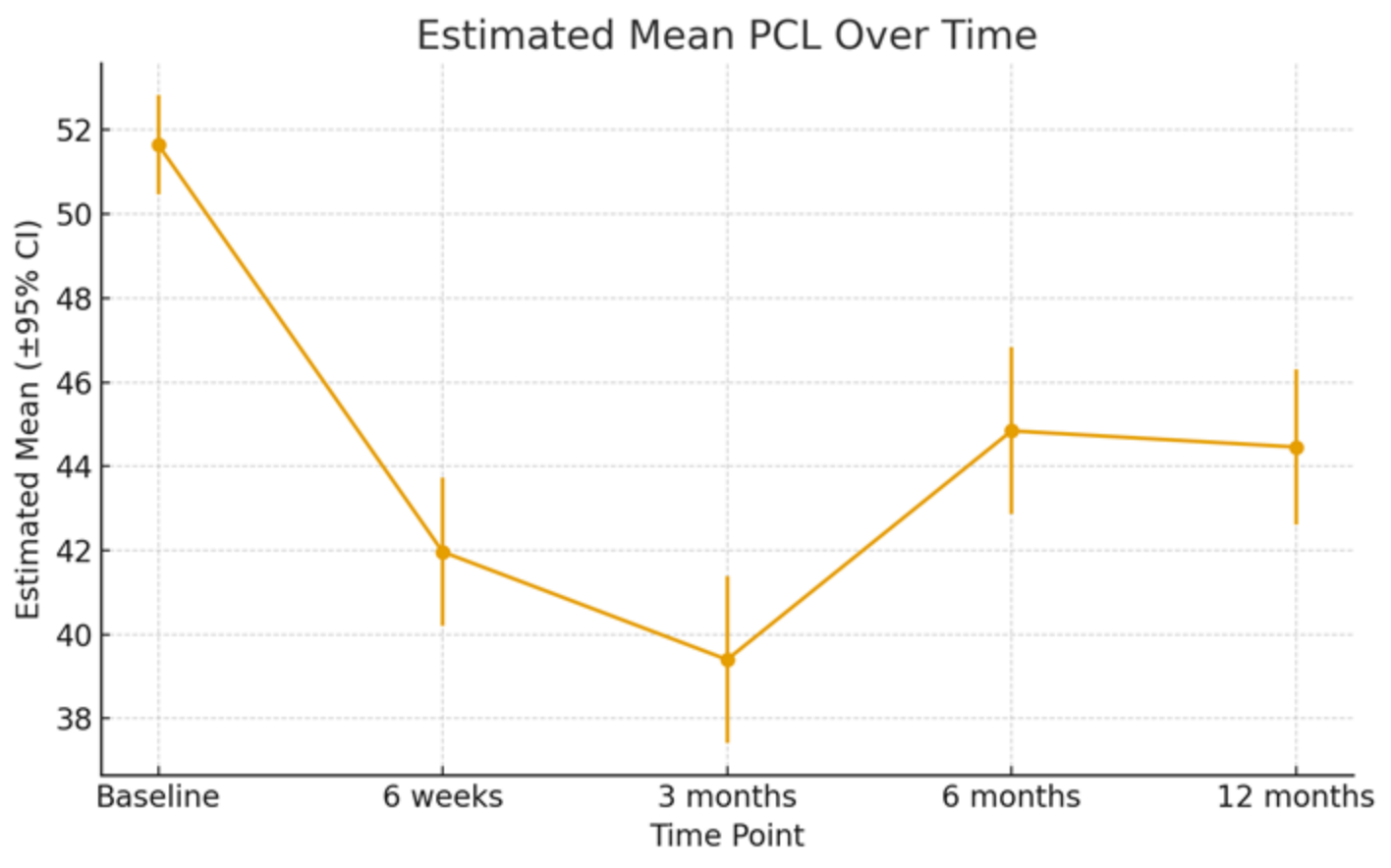
TICS · substance-use screening
Physical activity, unit contact, and return-to-service indicators

ASSESSMENT SCHEDULE

Not every instrument is administered at every time point; the battery is tailored to the clinical and follow-up stage.

Symptoms improve — but recovery is not linear

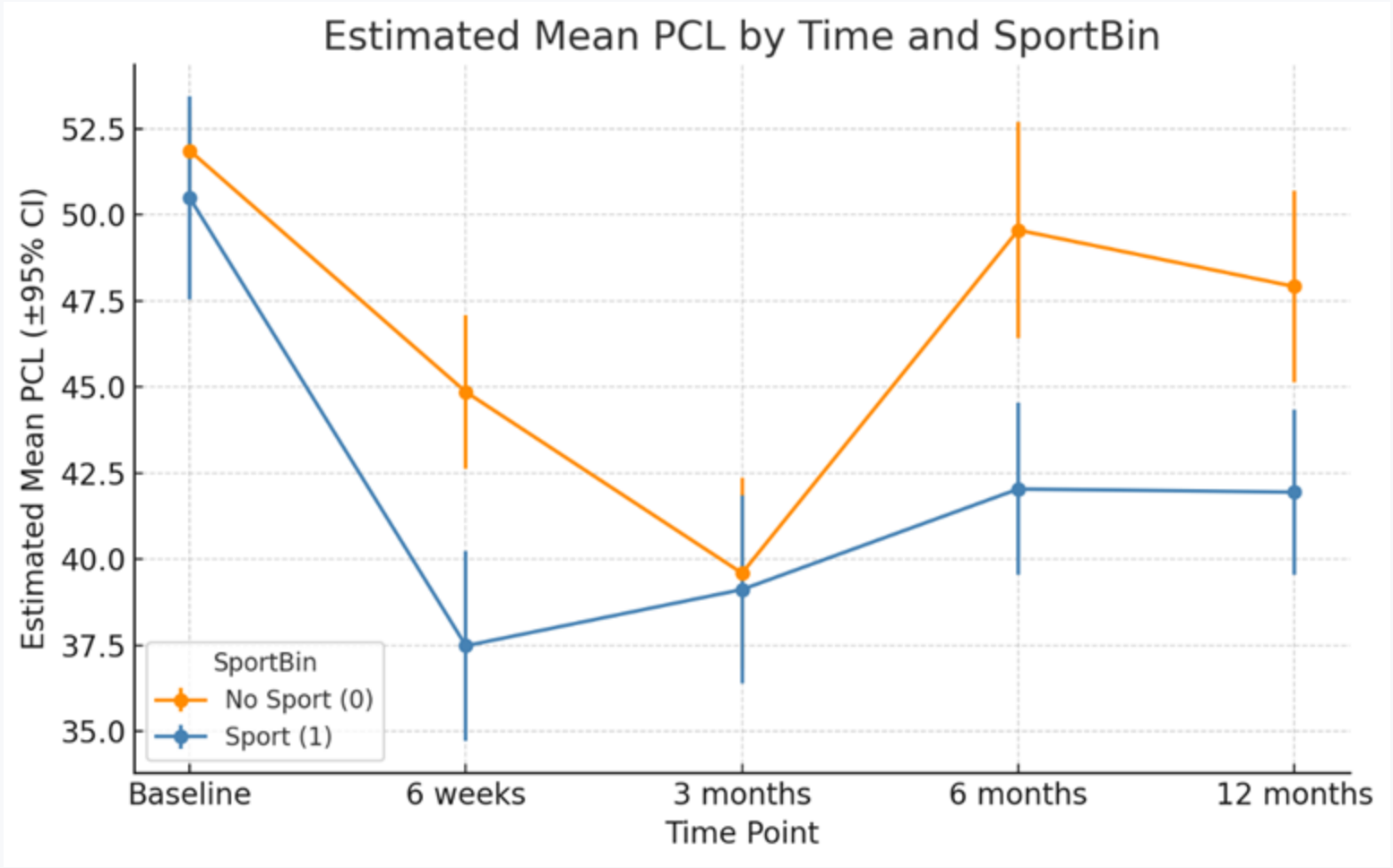
Mean PCL-5 scores declined early, followed by partial rebound at later follow-up.



Clinical interpretation

- Early treatment gains are meaningful.
- Later symptom fluctuation is common.
- Follow-up and continued support remain essential.
- Average trajectories can conceal distinct subgroups.

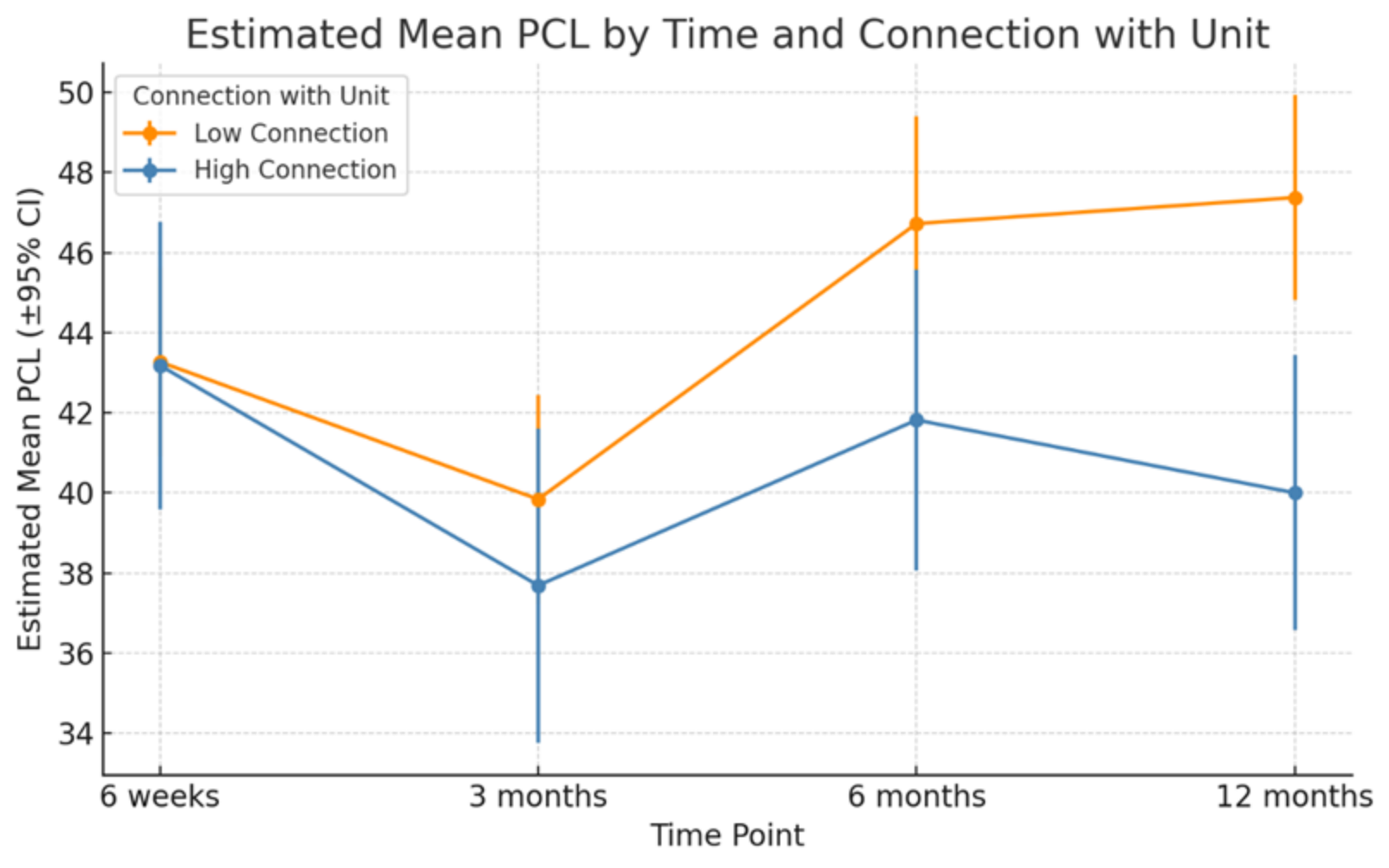
Change in Symptoms in Physically Active Patients



Clinical interpretation

- PTSD symptom trajectories differed by physical-activity status across follow-up.
- Association does not establish causality.

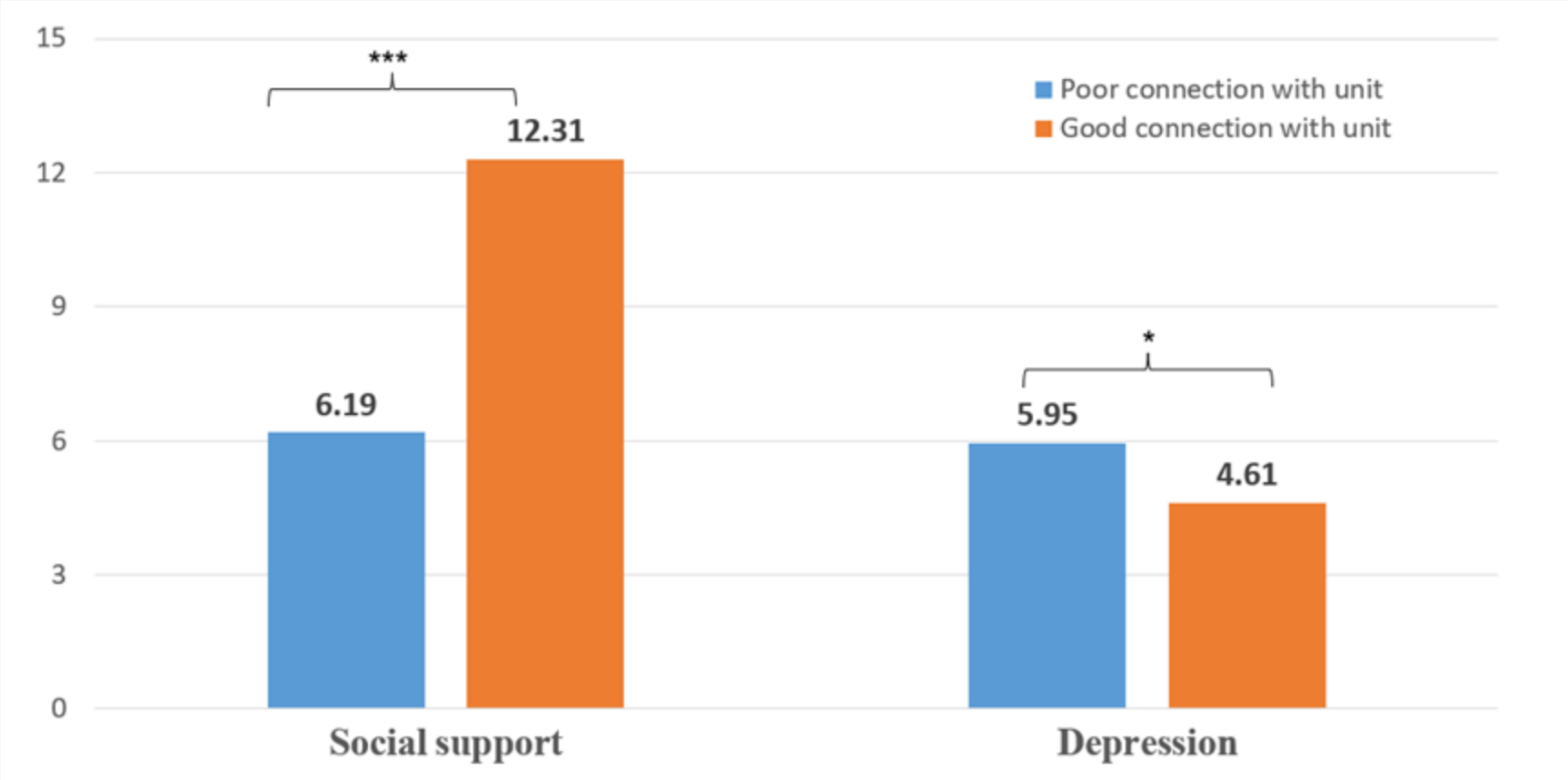
Symptomatic change among soldiers who did not maintain contact with their unit



Clinical interpretation

- Soldiers reporting stronger unit connection showed lower PCL-5 scores at later follow-up.
- Symptoms rose more sharply among those with weaker connection.
- Maintaining unit ties may be a clinically meaningful protective factor.

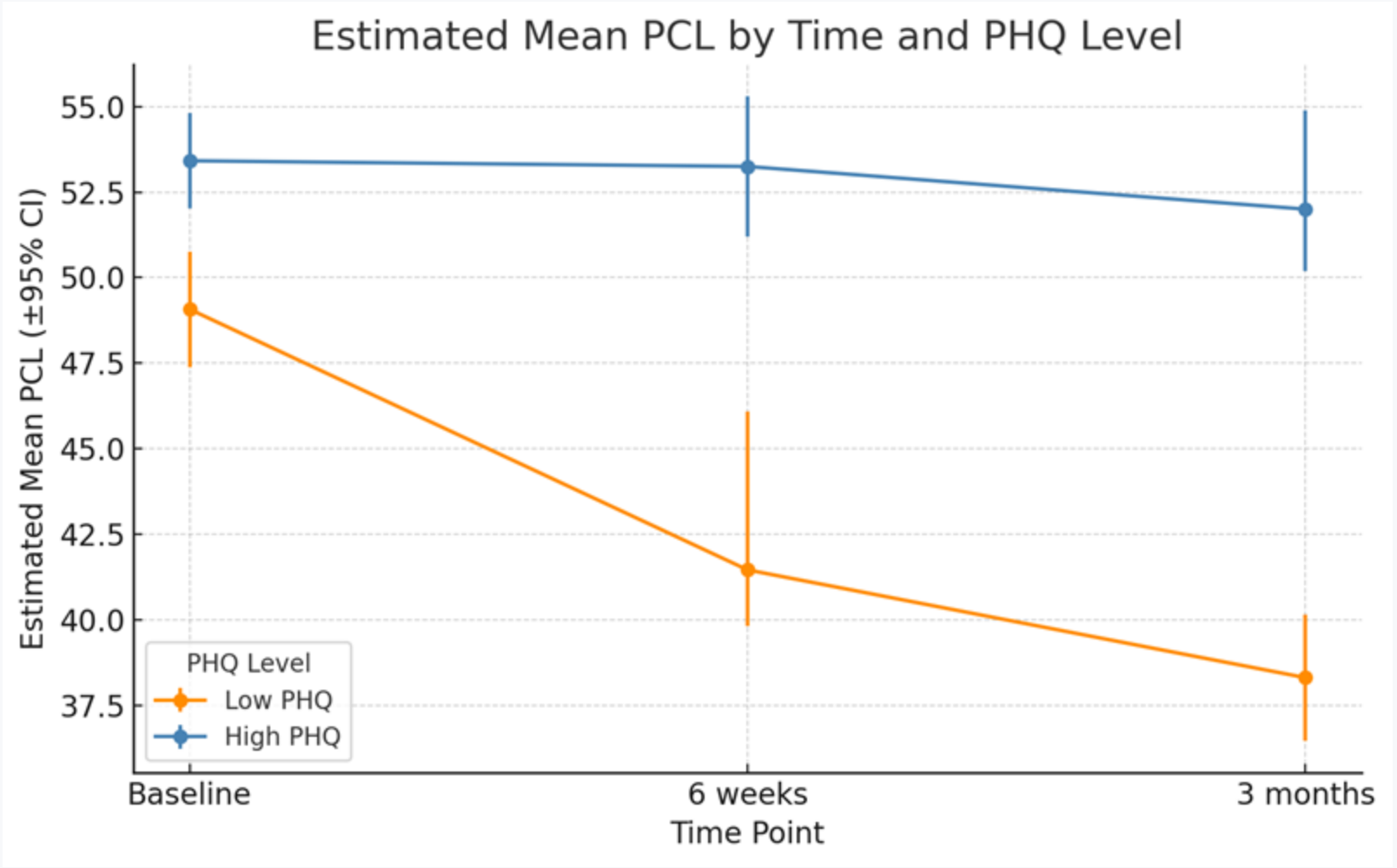
The Unit as a Source of Psychological Resilience



Clinical interpretation

- Good connection with the unit was associated with substantially greater perceived social support and lower depressive symptoms.
- The unit may therefore function as an important source of belonging and psychological protection.

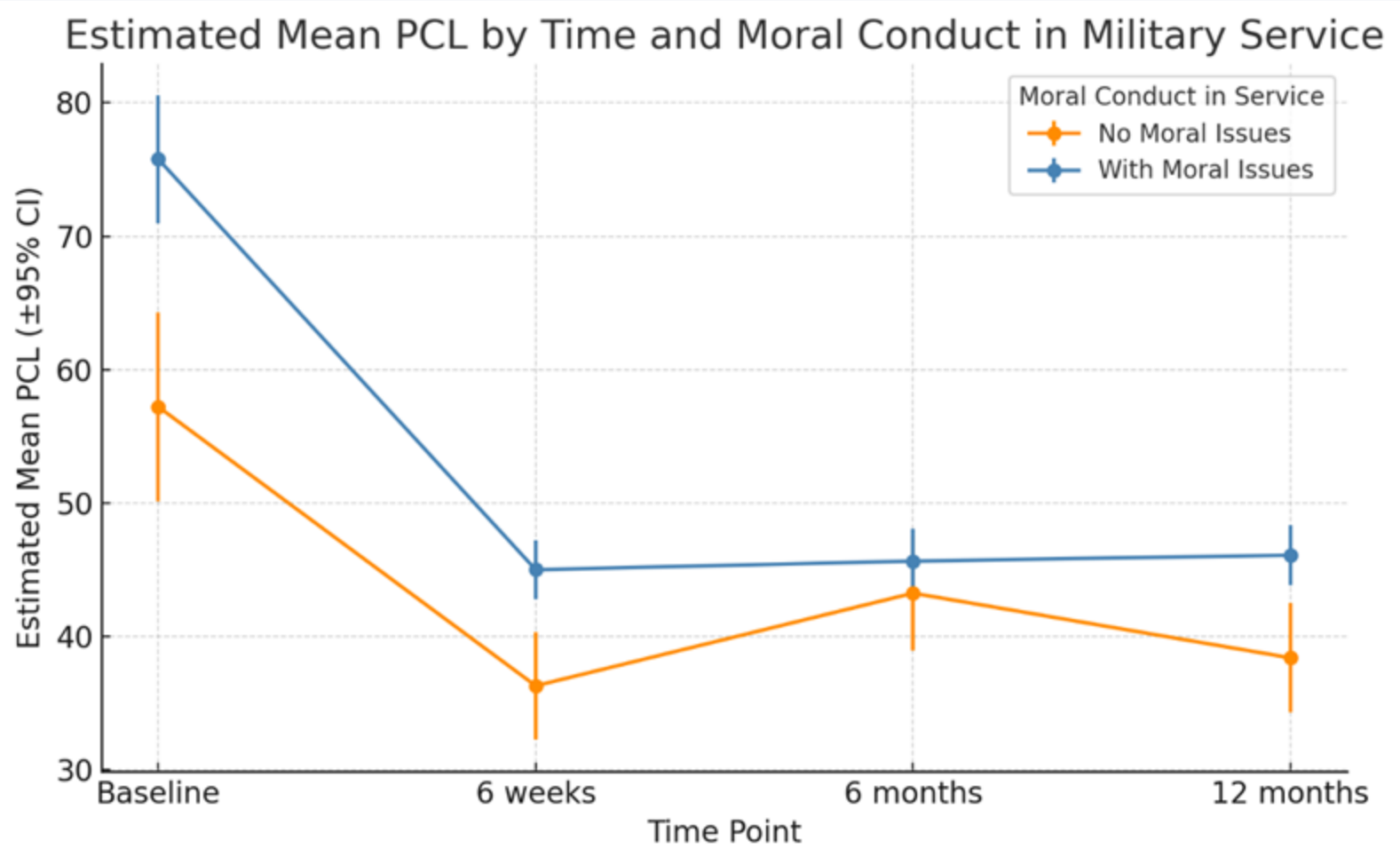
Patients with Both PTSD and Depressive Symptoms



Clinical interpretation

- Soldiers with higher depressive symptom levels had consistently higher PTSD symptom severity and showed less improvement over time.
- Depression appears to mark a more persistent and clinically complex trajectory.

Symptomatic change among soldiers who experienced moral injury



Clinical interpretation

- Soldiers reporting moral-injury experiences had higher PTSD symptom levels, particularly at baseline, with a gap that persisted during follow-up.
- Moral injury may identify a subgroup requiring targeted assessment and treatment.

Risk and protective factors shape the trajectory

Anxiety & depression

Risk

Strongest and most consistent predictors of higher PTSD symptom severity.

Moral injury

Risk

Associated with more persistent symptoms and poorer functional trajectories.

Unit connection

Protection

Maintaining contact with the unit was associated with better symptom trajectories and more support.

Physical activity

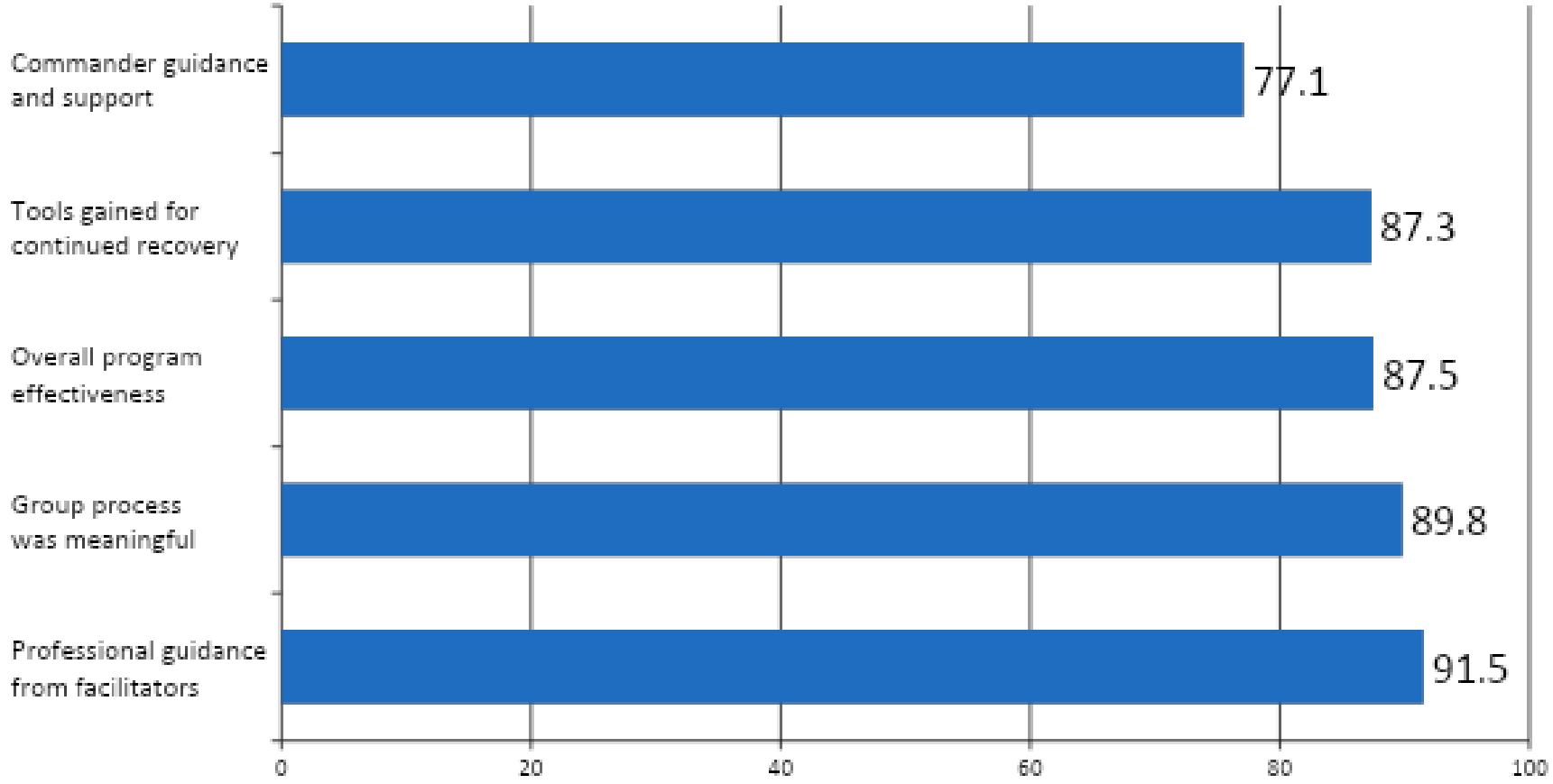
Protection

Regular activity was associated with more favorable symptom change over time.

Social support appears not only correlated with better outcomes, but may buffer the relationship between anxiety and PTSD symptoms

Participant Satisfaction Across 15 Cohorts

N = 716 | 5-point scale



Facilitator guidance
91.5% • 4.49/5

Group process
89.8% • 4.43/5

Program effectiveness
87.5% • 4.37/5

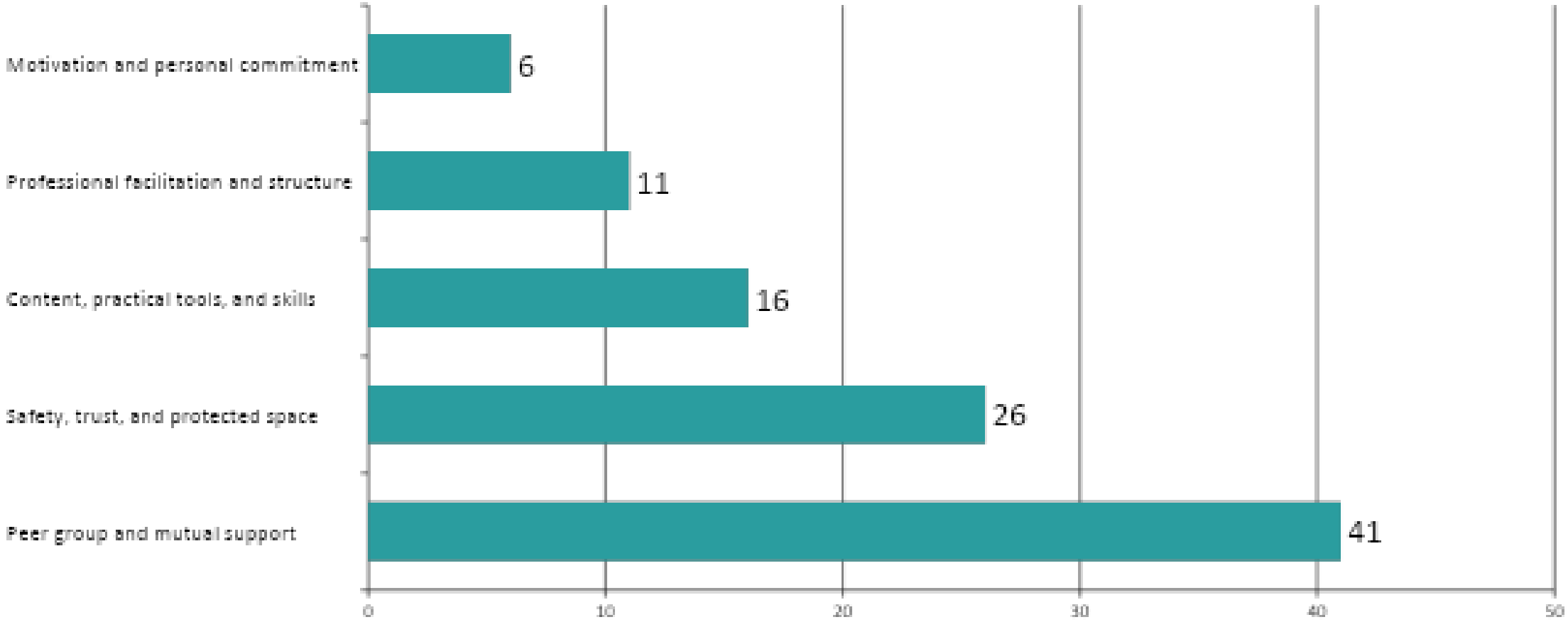
Recovery tools
87.3% • 4.32/5

Commander support
77.1% • 4.10/5

Nearly 9 in 10 participants rated the core treatment components highly; facilitator guidance received the strongest rating.

What Participants Identified as Drivers of Success

Open-ended feedback | N = 716



The peer group was the most frequently cited contributor to success, followed by safety, trust, and a protected treatment space.

Implications for military health systems

A specialty clinic can treat symptoms — but the system determines whether recovery becomes sustainable.

1

Identify early

Recognize intrusive symptoms, avoidance, sleep disruption, depression, and functional decline.

2

Keep the door open

Maintain unit contact and a credible path back to meaningful service.

3

Treat function explicitly

Build graded activity, responsibility, physical movement, and role restoration into care.

4

Measure over time

Use repeated outcomes to detect relapse, subgroup trajectories, and unmet needs.

Resilience is not only an individual trait; it is an outcome produced by systems that identify, treat, hold, and support.

Further research

1 Premorbid risk

How do sociodemographic factors and pre-enlistment screening variables predict later treatment needs and outcomes?

2 Trajectory prediction

Can we identify early who will recover, remain chronic, or deteriorate — and intervene differently?

3 Treatment matching

Which soldiers benefit most from intensive group care, enhanced outpatient care, or standard outpatient treatment?

4 Functional endpoints

Which clinical and system-level interventions best support sustained return to duty, reassignment, and quality of life?

Thank you

Questions & discussion

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