

Article 45

Comparison of Civilian Trauma and Combat Trauma

Kristin A. Vincenzes

Vincenzes, Kristin, is completing her PhD in Counselor Education & Supervision specializing in Trauma and Crisis at Walden University. She is a certified school counselor, licensed professional counselor (LPC) in Pennsylvania, and a national certified counselor (NCC). Kristin is an Assistant Professor at Lock Haven University and has extensive experience working with children in the school setting. Her areas of interest include: the military, online education, supervision for counselors, and self-care for mental health professionals.

Abstract

In an attempt to understand the impacts of multiple deployments on military service members, the author illustrates a comparison between civilian traumas and combat traumas. Furthermore, civilian single and multiple traumatic experiences are compared to military single and multiple traumas as experienced by veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). The author presents a literature review to compare these traumas in an effort to decipher potential differences in military veterans. Implications for counselors and researchers are noted.

As of 2007, the United States had sent 1.4 million military troops to serve in Iraq and Afghanistan (Korb, Rundlet, Bergmann, Duggan, & Juul, 2007). Due to the increasing needs in these two countries, 31 brigades (more than 420,000 troops) have served two or more tours in Iraq or Afghanistan (Korb et al., 2007; Tanielian & Jaycox, 2008). To further complicate the matters, numerous brigades who served in Iraq returned home for less than one year before deploying back to Iraq or Afghanistan for another tour (Korb et al., 2007). With the number of troops serving more than one tour, there are likely to be repercussions and lasting effects on these men and women who have little time to recover before serving abroad again. Of the men and women who served multiple combat tours, an Army survey revealed that soldiers are 50% more likely to suffer from post-traumatic stress disorder (PTSD) if they serve more than one tour (Army Medical Department, 2008).

Due to the relative newness of OIF and OEF, there are various deficiencies and gaps in the literature. For the purpose of this paper, the focus will be on multiple traumas and its relationship to combat veterans who served more than one tour to Iraq and/or Afghanistan. The paper will discuss civilian trauma (trauma experienced by someone not in the military) and the symptoms that may be found in relation to one's experiences. In addition, multiple civilian traumas will be compared to a single traumatic experience in

an effort to illustrate the differences that may occur when trauma is compounded. Next, military combat trauma will be discussed emphasizing trauma symptoms for veterans, which are different than those experienced through civilian trauma. In conclusion, implications for counselors, counselor educators, and future research will be discussed.

During the literature research, I attempted to find various articles that pertained to traumatic incidents. Various articles pertaining to the topic were found; however, there was a paucity of research pertaining directly to the effects of multiple deployments on active duty combat veterans. In order to make connections among the current research, I reviewed single and multiple traumas within communities that excluded military veterans as participants. In addition, I examined the literature pertaining to the veterans who served single deployments to the Vietnam War, Gulf War, and Iraq and Afghanistan wars. The impacts of these wars were needed to discuss the correlation (or lack thereof) to PTSD, post-traumatic stress symptomology (PTSS), depression, and alcohol use. Due to the increased number of soldiers that serve more than one deployment (Korb et al., 2007) and the paucity of research on this particular community of individuals, it is important that we understand the magnitude of the impact that several deployments may have on an individual. These effects could create ripples that may be seen in crime rates with veteran involvement, healthcare costs of veterans, increased divorce rates in this population, and increased domestic violence among the military population.

Civilian Trauma

Trauma is frequently reported to be associated with various psychiatric conditions such as post-traumatic stress disorder (PTSD). Often, individuals with PTSD show similar symptoms noted in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*, American Psychiatric Association, 2000). These symptoms include: nightmares, flashbacks, intrusive memories, avoidance of reminders of the trauma, emotional numbing, social isolation, irritability and anger outbursts, hypervigilance, difficulty with concentration and memory, panic-level anxiety, and depression with suicidal ideation (APA, 2000). However, recently researchers are beginning to study the differences of onset and frequency on PTSD symptoms in various traumas.

Post-traumatic symptoms are not always the same for everyone. Hagenars, Fisch, and van Minnen (2011) studied patients who suffered through single and multiple traumatic incidents (none of the individuals in the study were military) and found that patients with multiple trauma incidents exhibited different PTSD symptoms than those who experienced a single trauma. Furthermore, they discovered significant differences in that multiple trauma patients had higher levels of dissociation, anger, guilt, and shame. In addition, they found a statistically significant difference in interpersonal sensitivity suggesting a heightened level of distrust in relationships (Hagenars et al, 2011).

Multiple Traumas

In an attempt to better understand this need, some researchers specifically studied multiple traumas in relation to PTSD. Breslau, Chilcoat, Kessler, and Davis (1999) discovered that individuals with previous trauma, especially assaultive violence, were more likely to experience PTSD. In addition, they found that after five years from the

previous trauma, the risk of PTSD from a new trauma is twice as high for those who experienced assaultive violence than those who experienced trauma that was not an assault. Scott (2007) corroborated this research and also found a significant correlation between the number of traumas and the level of PTSD symptoms. In addition, there was a positive correlation between the severity of the trauma and the severity of PTSD symptoms with community violence as the strongest correlation to PTSD symptoms. These findings targeting multiple traumas, multiple traumas within short time periods, and violent traumas imply the need to look at military combat veterans serving multiple deployments within short time-spans. Could the mental health findings indicated by previous researchers who studied multiple traumas (Breslau, et al., 1999; Hagenars, et al, 2011; Scott, 2007) be replicated with military veterans serving multiple deployments?

Military Trauma

Military combat exposure is a significant area of concern in relation to the mental health effects experienced by veterans. Post-traumatic stress disorder (PTSD) is a serious concern plaguing veterans returning from Iraq and Afghanistan. Hoge et al. (2004) found that 30% of veterans returning from their first deployment suffered from depression, anxiety, or PTSD. Similarly, a recent study found that 20.3% of active duty veterans and 42.4% of veterans who served in the Reserves required mental health treatment (Milliken, Auchterlonie, & Hoge, 2007). Taft, Schumm, Panuzio, and Proctor (2008) found that high exposure to combat situations was associated with higher PTSD symptoms for veterans.

Ramchand et al. (2010) reviewed 29 studies to compare the prevalence of PTSD symptoms in veterans who served in OIF and OEF. Results of the comparisons found that there is a variation between prevalence estimates among veterans of OEF and OIF. Due to this variability, Ramchand et al. (2010) recommended that there needs to be a common method to define PTSD. In addition, it was suggested that the exposure to various combat situations be discussed when studying PTSD for veterans (Ramchand et al., 2010).

Although various findings have indicated a direct relationship between deployment and post-traumatic stress symptomology (PTSS) and PTSD, it is important to decipher any possible differences in the types of symptoms experienced by the veterans. Tuerk, Grubaugh, Hamner, and Foa (2009), completed case studies on two returning Iraq-war veterans and found one noticeably different symptom—compulsive checking behavior. For the two veterans in the case study, compulsive checking was a signifying concern because they were continuously checking doors, windows, or their vehicles to make sure no one was coming and that they were safe (Tuerk et al., 2009). Tuerk et al. believed that these behaviors are similar to the PTSD symptom of hypervigilance. In relation to the PTSD symptom of hypervigilance, Garcia, Finley, Lorber and Jakupcak (2011) found that masculine norms are associated with these symptoms. More specifically the masculine norm exaggerated self-reliance and control, positively predicted hyperarousal symptoms for military veteran males (Garcia et al., 2011); therefore, gender may also be an important component with this specific PTSD symptom found in many OIF and OEF veterans.

In accordance to these findings, Khaylis, Polusny, Erbes, Gewirtz, and Rath (2011) studied PTSD, family adjustment, and treatment preferences among National Guard veterans of OEF and OIF. After a recent deployment to Iraq or Afghanistan, soldiers reported concerns with relationships with either their significant other or their children. Furthermore, PTSD symptoms were significantly correlated to relationship concerns, thus illustrating the increased interest in the veteran population because of the complexity of symptoms that may differ from the specific symptoms located in the *DSM-IV-TR* (APA, 2000). It may be important to research this area further to possibly expand on post-traumatic stress symptomology. The veterans serving in OIF and OEF are experiencing somewhat different PTSD symptoms, which need to be understood in order to properly diagnose and treat the soldiers upon redeployment.

Combat Exposure

Although there is little research pertaining directly to the effects of multiple deployments, many researchers have studied the effects of different variables of deployment and how they may attribute to PTSD. One variable that researchers are interested in is the idea of combat exposure and its effects on PTSD. Foy, Sippelle, Rueger, and Carroll (1984) studied Vietnam veterans and PTSD and found that the extent of combat exposure was significantly related to PTSD symptomology. In addition to these findings, Taft et al. (2008) examined the interrelationships among combat exposure, symptoms of PTSD, and family adjustment for Desert Storm veterans. Results found that high exposure to combat situations was associated with higher PTSD symptoms, which then affected family relationships and adjustment upon redeployment. Although the findings were not statistically significant, there was a defined negative association between the variables.

With the increasing numbers of soldiers deployed to Iraq and Afghanistan, the interest of its impacts on the soldiers is rising. Hoge et al. (2004) found that those exposed to combat in Iraq had significantly higher ratings of major depression, PTSD, and generalized anxiety. In order to decipher possible causes to these rates, Hoge et al. (2004) looked at the impact of shooting and/or killing others during combat. They found 77-87% of soldiers in infantry units from OIF reported shooting or directly firing at the enemy, 48-65% reported being responsible for the death of an enemy, and 14-28% reported being responsible for the death of a noncombatant. Hoge et al. also looked at the rates of individuals seeking mental health care and found only 23-40% sought mental health care assistance. This is an alarming amount of individuals who are not seeking help. Of those who did not seek assistance, Hoge et al. found that those who scored positive for mental health issues were twice as likely not to report any problems because of possible stigmas. Many soldiers fear that they will be looked down upon for seeking help or their military career will be severely impacted for reporting a mental health concern.

Maguen et al. (2010) examined the relationship between exposure to killing in combat and depression and alcohol use. Maguen et al. (2010) found that 77% reported seeing dead bodies and 56% reported witnessing killing but there was no direct effect between the variables. Maguen et al. (2010) also examined the relationship between killing and mental health concerns among Gulf War veterans. Maguen et al. (2010) found that younger males were more likely to report killing. In addition, 20% of the veterans

reported meeting the PTSS (post-traumatic stress symptomology), 45% reported depression, and 6% had current alcohol problems (Maguen et al., 2010). After controlling for perceived death, witnessing death, and exposure to death, killing was a significant predictor of PTSS (Maguen et al., 2010).

The National Center for PTSD (n.d.) estimates between 12-20% of soldiers returning from Iraq will have symptoms of PTSD. As of 2007, 1.4 million soldiers have served in Iraq or Afghanistan, which puts the number of affected soldiers in the hundreds of thousands. In addition, Seal, Bertenthal, Miner, Sen, and Marmar (2007) found that soldiers 18-24 years old were at greater risk for receiving a mental health diagnosis.

Comparing Civilian Trauma and Combat Trauma

Due to the high number of veterans who have served in OIF and/or OEF, it is important to clearly understand the ramifications of these wars. Civilian trauma was used as a basis in illustrating that military veterans experience different PTSD symptoms. Although there are notably different symptoms such as hypervigilance and compulsive checking, one potential area of similarity is both combat trauma and civilian trauma result in relational issues with significant others and/or their children (Hagenaars et al, 2011; Khaylis et al., 2011). Distrust is a common theme for both traumas; therefore, relationships must be addressed regardless of the type of trauma.

Another comparison between civilian trauma and combat trauma was in relation to multiple traumas. Due to the paucity of research regarding multiple deployments, researchers could use the complexity of civilian multiple traumas as a potential frame of reference to understanding veterans' emotional struggles as they continue to deploy and re-engage in traumatic experiences. However, it is important to note that one of the significant differences between civilian trauma and combat trauma is that it is not unusual for veterans to have repeatedly witnessed death or to have been responsible for multiple deaths. With repetitive exposure and experience to this type of trauma, it may significantly increase the experienced PTSD symptoms over multiple deployments.

Implications for Counselors and Counselor Educators Working With Veterans

One implication for counselors lies with the technique utilized to treat veterans upon redeployment. The relationship stressors identified by Khaylis et al. (2011) and Hagenaars et al. (2011) could imply the need to pay close attention to reintegrating veterans into positive relationships with their significant others, family, friends, and community. Individual as well as couple therapy for veterans and their loved ones may prove to be beneficial. In addition, Tuerk et al. (2009) found that response prevention assisted in the significant treatment gains of the two veteran case studies who recently deployed to Iraq.

A second implication for counselors is understanding and identifying compulsive checking behaviors. This symptom may be similar to hypervigilance in PTSD (Tuerk et al., 2009) and needs to be carefully examined as a strong determination of a mental health diagnosis. In accordance, this symptom may need to be further studied for a possible integration into the classification of PTSD. In an attempt to counsel the veterans of OIF

and OEF, cognitive behavioral conjoint therapy is suggested to assist new veterans and their PTSD symptoms (Fredman, Monson, & Adair, 2011).

Finally, counselors need to be advocates for the veterans and their families. Counselors can be advocates by increasing awareness of the severity of PTSD symptoms, how symptoms may present themselves, and the normalcy of them, which may give confidence to soldiers to seek treatment. Getting information to the veteran's family members may also be advantageous because it will again increase awareness and possibly help them to understand their soldier's symptoms. In turn, the loved ones may be able to offer additional support and encouragement to receive treatment.

Implications for Researchers Interested in the Veteran Population

One key issue that needs to be addressed is the overwhelming number of veterans whose mental health needs are not being serviced. Further research needs to be completed regarding possible stigmas and other reasons as to why soldiers are not seeking help. Are soldiers fearful that fellow combat soldiers and officers will view them as incapable of the job if they seek mental health services? Are they concerned with how they will be perceived by the men and women who they are in charge of?

Studies also need to be conducted as to the appropriate times to screen for PTSD. During the initial couple of days after returning to the states, the soldiers are required to fill out various surveys and questionnaires regarding their mental health status. In addition, the impact of combat exposure could take months until the soldier is able to recognize the symptoms and signs; however, this is extremely difficult to attend to when soldiers are serving multiple deployments with an insufficient amount of time at home before deploying again. This needs to be further addressed so that we can assure soldiers are receiving the proper healthcare they need to reintegrate into society. Furthermore, we need to discover how we can decrease these barriers to getting appropriate mental health care. Educating both the soldiers and their leaders in identifying post-traumatic stress disorder will be crucial to the first step in receiving mental health services.

Another area of research needs to address the differences between a combat military occupation specialty (MOS) veteran and a non-combat MOS veteran who served in Iraq or Afghanistan. Many soldiers in a non-combat MOS do not leave the compounds as frequently while serving abroad. A combat MOS soldier may be sent into potentially traumatic situations daily. In addition, when these soldiers return from a deployment, a combat MOS soldier may be continuously training in high stressful simulated missions whereas non-combat MOS soldiers are able to relax upon redeployment. These circumstances may attribute to higher rates of post-traumatic stress disorder in this specific population.

A final area of research needs to be allocated to the paucity of information regarding the lack of time spent between deployments and the possible effects of insufficient time to regain positive mental health. Various brigades are deploying for twelve or more months, only to spend less than a year home before returning to another tour (Korb et al., 2007). This factor may compact the symptoms of PTSD. For many soldiers, they do not spend enough time at home to recuperate psychologically and physically; therefore, when they return to Iraq and Afghanistan, their mental and physical health are already compromised.

Conclusion

This article attempted to both distinguish and compare single and multiple traumas between civilians and veterans. Although there may be some differences between the two in regards to specific behaviors, when traumas are compounded, there may be more similarities. Thousands of military combat veterans are deployed at rapid rates for extensive periods of time. These deployments can have lasting effects on both the soldiers and their families. It is important that our country begins to recognize the long-term effects of multiple lengthy deployments so that we can begin to help these soldiers effectively transition from war zones to home. A positive transition will not only assist in the well-being of the soldier and their family but will allow the soldier to maintain a positive role serving in the United States military.

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