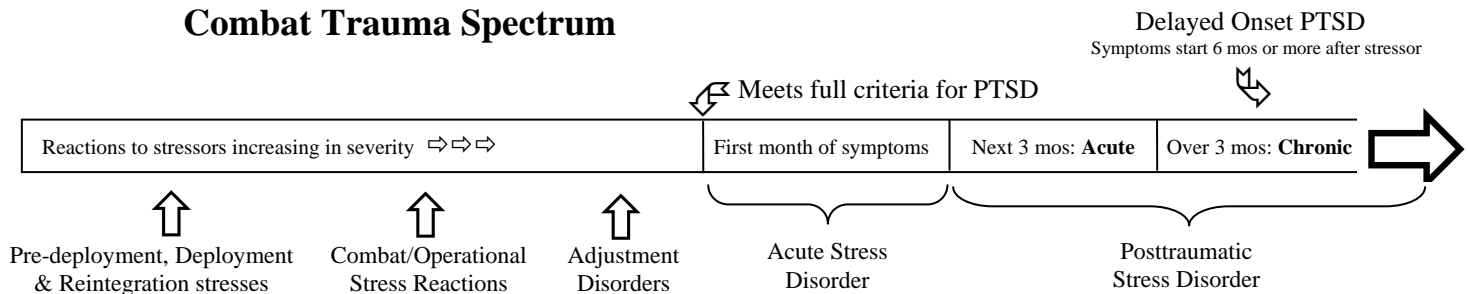


Combat Trauma Definitions

This paper is meant to be a clarifying document for Campus Crusade for Christ's Military Ministry on the subject of Combat Trauma. The following diagram will help put the various terms in context.



Combat Trauma: A general term we apply to the spectrum of distressing reactions a troop may have to the trauma of combat. It would include all conditions from the mild end of the spectrum (Pre-deployment, Deployment & Reintegration stresses) to the severe end of the spectrum (PTSD). The term “Combat Trauma” describes the same spectrum of conditions that the U.S. Army Center for Health Promotion & Preventive Medicine calls “**Deployment-Related Stress.**” We’ve chosen to use the Combat Trauma term because we feel it communicates the concept more succinctly and easily links with terms and concepts the general public has already heard about (such as “combat” and “**Posttraumatic** Stress Disorder”).

We also recognize that all levels of Combat Trauma can be experienced by troops who were deployed in roles that were not directly combat-related. Long periods of sleep-deprived duty, monotony and stressful assignments while far from home and family can produce various levels of stress and anxiety in deployed troops. When these conditions are combined with living under the imminent threat of mortar and RPG attacks, IEDs and car bombs, the symptomology can rise to the level of Acute Stress Disorder and PTSD. We reason that combat operations (or the threat of combat) dictate *all* deployments and so even “non-trigger-pullers” are still involved in combat to some degree and could therefore be considered “Combat Trauma sufferers” as well when they exhibit the same symptoms.

Pre-deployment stresses: Immediate anxiety when notified of an impending deployment; wide range of emotions; financial, emotional and logistical stresses involved with preparing the family for the troop’s absence; increase in training tempo in preparation for the mission; traumatic outbursts for couples who don’t know how to cope with the looming reality of long-term separation.

Deployment stresses: Being on life-or-death alert almost all of the time; taking part in traumatic, horrific events; physical woundings; near-death experiences; wounding and death of comrades; concern for family’s welfare while downrange; anxiety over kids’ development; missing out on important family occasions, births, deaths; fears regarding the spouse’s loyalty and fidelity while separated; poor communication infrastructure; feeling of helplessness regarding family emergencies; loneliness; boredom; fatigue; sleep deprivation; discomfort; fear; sadness; exhaustion.

Reintegration Issues: Tension that increases in a returning troop (and his/her spouse and children if married) as they encounter various difficulties during the transition from deployment back to home and family life. Pursuits and concerns that bring about this tension can include:

- Changing the troop’s main emotional link and support from his military buddies back to his wife or family.
- Resuming and sharing household/family roles.
- Getting used to communicating with his/her spouse on an intimate, frequent basis again.
- Adjusting to the different level of order and control in the home than he was used to while deployed.
- Adjusting to different family dynamics due to the aging of the children.
- Adjusting to a spouse’s transition who lived with his/her parents or in-laws while the troop was deployed.

- Adjusting to a spouse who has become more independent and self-sufficient while the troop was deployed.
- Knowing how much or how little to communicate regarding his/her experiences while deployed.
- Coordinating with his/her spouse regarding child-rearing and child-discipline issues.
- Coordinating with his/her spouse regarding spending, saving and budgeting issues.
- Dealing with issues of mistrust and jealousy after a long time apart.
- Synchronizing his/her emotional and sexual needs and expectations with those of his/her spouse.
- Getting used to altered psychological and social skills and responses due to Combat Trauma.
- Broadening life focus from military missions 24/7 to include other family-oriented pursuits.
- Establishing a healthy regimen of diet, exercise and sleep.
- Deciding how major and day-to-day decisions are to be made in the home.
- Adjusting to different job roles and responsibilities; new co-workers.
- Navigating the complicated bureaucracy involved in all military transitions.
- Ramping down the constant state of arousal that was necessary while in a combat zone.
- Staying on top of legal and financial issues.
- Medical examinations; dealing with wounds, physical therapy, counseling.
- Dealing with multitudinous briefings, debriefings, training sessions and surveys.
- Adjusting to the spouse's faith convictions and practices that may have been altered during deployment.
- Enjoying welcome home ceremonies without them becoming burdensome or triggering events.

Sources: "Spouse Battlemind Training," brochure produced by Walter Reed Army Institute of Research, January 2007; "Courage To Care: Becoming A Couple Again" handout by the Uniformed Services University of the Health Sciences (www.usuhs.mil), Summer, 2004; "Roadmap To Reintegration" by U.S. Army Europe found at www.per.hqusaar.army.mil/reintegration, June, 2008.

Combat/Operational Stress Reactions, or COSRs, are normal¹ reactions to abnormally stressful events – such as combat or other dangerous operations. COSRs are **not** a medical illness, and people who experience COSRs are **not** sick or weak. COSRs are our bodies' way of protesting or slowing us down when we have pushed ourselves past the regular limits of endurance. The "symptoms" of COSRs can look a lot like the symptoms of PTSD, Acute Stress Disorder or Adjustment Disorders. The difference, though, is that the typical COSR has only a few symptoms, and they tend to occur *immediately* after stressful action and get better quickly without significant "treatment."

Source: U.S. Army Center for Health Promotion & Preventive Medicine brochure: "Redeployment Health Guide: A Service Member's Guide to Deployment-Related Stress Problems" January, 2006

COSR symptoms include (but are not limited to):

tension	worrying	rapid breathing	trouble communi-
aches	expecting the worst	out-of-breath	cating
pains	irritable	fingers and toes tingle	troubled sleep
jumpiness	complaining	upset stomach	bad dreams
fidgety	easily bothered	vomiting	full of grief, crying
trembling	poor attention	diarrhea	self-blame
cold sweats	poor mental focus	constipation	angry at leaders
dry mouth	can't remember	frequent urination	low confidence
pale skin	details	urgent urination	loss of faith in self
eyes hard to focus	heart pounding	tired; drained	loss of faith in unit
anxiety	dizzy	great effort to move	
keyed up	light-headed	1000-yd stare	

Source: U.S. Army Center for Health Promotion & Preventive Medicine online database: "Guide to Coping With Deployment and Combat Stress" (www.usachppm.apgea.army.mil) USACHPPM TG320, Feb, 2008, pp. 7,8.

Adjustment Disorders: The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s) and resolving within an additional six months.

These symptoms or behaviors are clinically significant as evidenced by *either* of the following:

- Marked distress that is in excess of what would be expected from exposure to the stressor.
- Significant impairment in social or occupational (academic) functioning.

The general categories of Adjustment Disorder symptoms include **depression** (tearfulness, feelings of hopelessness), **anxiety** (nervousness, worry, jitteriness) and **disturbance of conduct** (violation of the rights of others, e.g., truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities) or a combination of those three.

Once a stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional six months. However, if the symptoms occur in response to a chronic stressor (e.g., a disabling medical condition) or to a stressor that has enduring consequences (e.g., financial and emotional difficulties associated with a divorce), they may persist beyond six months and it is termed **Chronic Adjustment Disorder**.

Adjustment Disorder can be triggered by a stressor of any severity and may be a single event or multiple events. They may be recurrent or continuous events. They may affect a single individual, an entire family, or a larger group or community. Bereavement due to the death of a loved one is not considered a stressor unless the reaction is in excess of, or more prolonged than, what would be expected.

Source: (DSM-IV-TR) American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. (Washington, D.C. APA, 2000). pp. 679-683.

Acute Stress Disorder: The development of characteristic anxiety, dissociative and other symptoms that are experienced during or immediately after a traumatic event (and begin within a maximum of four weeks of the traumatic event), last for at least two days, and either resolve within four weeks after the conclusion of the traumatic event or the diagnosis is changed. When symptoms persist beyond one month, a diagnosis of Posttraumatic Stress Disorder may be appropriate if the full criteria for PTSD are met. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning or impair the individual's ability to pursue some necessary task. The stressors involved are the same as described for Posttraumatic Stress Disorder.

The characteristic symptoms include:

- Either while experiencing or after experiencing the distressing event, the individual has *three* or more of the following **dissociative** symptoms:
 1. A subjective sense of numbing, detachment, or absence of emotional responsiveness.
 2. A reduction in awareness of his or her surroundings (e.g., "being in a daze").
 3. Derealization (an alteration in the perception or experience of the external world so that it seems strange or unreal).
 4. Depersonalization (a subjective experience of unreality in one's sense of self).
 5. Dissociative amnesia (i.e. inability to recall an important aspect of the trauma).
- The traumatic event is persistently **reexperienced** in at least *one* of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, a sense of reliving the experience, or distress on exposure to reminders of the traumatic event.
- Marked **avoidance** of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- Marked symptoms of anxiety or increased **arousal** (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- The disturbance cannot be one that is caused by the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g. head trauma).

Source: (DSM-IV-TR) American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. (Washington, D.C. APA, 2000). pp. 469-472.

Posttraumatic Stress Disorder: The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror.

The characteristic symptoms include:

- Persistent **reexperiencing** in *one* or more of the following ways:
 1. Recurrent and intrusive distressing recollections of the event including images, thoughts, perceptions.
 2. Recurrent distressing dreams of the event.
 3. Acting or feeling as if the event were recurring (reliving, illusions, hallucinations, dissociative flashback episodes including while awake or intoxicated).
 4. Intense psychological distress at exposure to cues that symbolize or resemble an aspect of the event.
 5. Physiological reactivity to cues that symbolize or resemble an aspect of the event.
- Persistent **avoidance** of stimuli associated with the trauma and numbing of general responsiveness as indicated by *three* or more of the following:
 1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.
 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
 3. Inability to recall an important aspect of the trauma.
 4. Markedly diminished interest or participation in significant activities.
 5. Feeling of detachment or estrangement from others.
 6. Restricted range of affect (e.g., unable to have loving feelings).
 7. Sense of foreshortened future (e.g., shortened or no career, marriage, children, or normal life span).
- Persistent symptoms of increased **arousal** as indicated by *two* or more of the following:
 1. Difficulty falling or staying asleep.
 2. Irritability or outbursts of anger.
 3. Difficulty concentrating.
 4. Hypervigilance.
 5. Exaggerated startle response.

The symptoms must last more than one month (otherwise it is Acute Stress Disorder), and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. If the duration of symptoms is less than three months, it is termed **Acute PTSD**. If the duration of symptoms is three months or more, it is termed **Chronic PTSD**. If the onset of symptoms is at least six months after the stressor, it is termed **PTSD With Delayed Onset**.

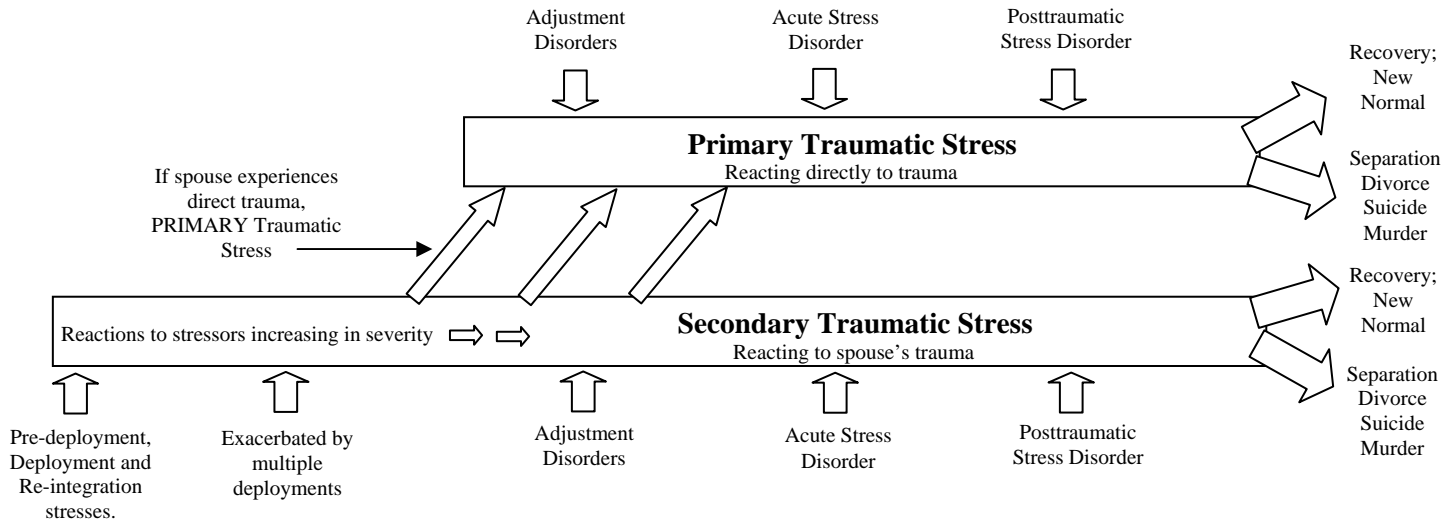
Source: (DSM-IV-TR) American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. (Washington, D.C. APA, 2000). pp. 463-468.

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Spousal Secondary Trauma

This section is intended to explain Secondary Traumatic Stress seen in the spouses of veterans who suffer from Combat Trauma, and to show how it relates to Primary Traumatic Stress and to the Combat Trauma Spectrum. The following diagram will help put the various terms in context.

Secondary Trauma Spectrum



Spousal Secondary Trauma: A general term we apply to the spectrum of distressing reactions a person may have to their spouse who is suffering from the trauma of combat. It would include all conditions from the mild end of the spectrum (Pre-deployment, Deployment and Re-integration stresses) to the severe end of the spectrum (PTSD). Though the spouse was not involved in combat, her/his anxiety and distress is the direct result of her husband (or his wife) being involved in and traumatized by combat.

Secondary Traumatic Stress defined:

- “It is the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person.” [Source: Dr. Charles R. Figley “Compassion Fatigue: Toward a New Understanding of the Costs of Caring” in Dr. B.H. Stamm (Ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators* (2nd ed.) (Lutherville, MD: Sidran, 1999). p. 10.]
- “The distressing experiences of people who communicate at a deep level with someone who has been traumatized and become traumatized as well.” [Source: Dr. Charles R. Figley (Ed.), *Treating Compassion Fatigue* (New York: Routledge, 2002). pp.2,3.]
- “STS, or even STSD, is a natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first’s traumatic experiences.” [Source: Dr. Charles R. Figley (Ed.), *Compassion Fatigue – Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York: Brunner-Routledge, 1995). p. 11.
Note: Though Dr. Figley – one of the world’s foremost authorities in Secondary Trauma – uses the term “**Secondary Traumatic Stress Disorder**,” we won’t be utilizing the term because it has yet to be formally defined by the professional mental health community at large.
- Secondary Traumatic Stress is also called “Compassion Stress” [Source: Charles R. Figley (Ed.), *Compassion Fatigue – Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York: Brunner-Routledge, 1995). p. xv, 2, 3, 14, 15.]

Spouses of Combat Trauma Sufferers can experience Traumatic Stress in two ways:

- Reacting to hearing about his/her spouse's traumatic experiences (Secondary Traumatic Stress)
- Being traumatized directly by his/her spouse's behavior (Primary Traumatic Stress)

People who experience Secondary Traumatic Stress can exhibit the same symptoms as those who experience Primary Traumatic Stress – even to the level of Posttraumatic Stress Disorder (also called “Compassion Fatigue” when experienced secondarily):

- “The negative effects of secondary exposure to a traumatic event are nearly identical to those of primary exposure, with the difference being that exposure to a traumatizing event experienced by one person becomes a traumatizing event for a second person. Chrestman (1999) noted that secondary traumatization of clinicians has been hypothesized to include symptoms parallel to those observed in persons directly exposed to trauma, such as intrusive imagery related to the client's traumatic disclosures, avoidant responses, physiological arousal, distressing emotions and functional impairment.” [Source: Dr. Brian E. Bride, program director at the University of Georgia School of Social Work: “Development and Validation of the Secondary Traumatic Stress Scale” *Research on Social Work Practice*, Vol. 13 No. x, 2003.]
- It is possible for a person to develop the symptoms of PTSD through experiencing a trauma secondarily. Note the definition of PTSD in the DSM-IV: “. . . or *learning about* unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. . . Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease.” [Source: DSM-IV-TR, p. 463, 464. Figley made the same observation in *Compassion Fatigue – Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, p. 4.]
- [Defining Secondary Traumatic Stress]: “One of several terms, including “compassion stress,” “compassion fatigue,” and “secondary victimization” (Figley, 1983), “co-victimization” (Hartsough & Myers, 1985), “traumatic countertransference” (Herman, 1992), and “vicarious traumatization” (McCann & Pearlman, 1989) that have been used to label the manifestations and processes of distress reported by persons in close proximity to victims of traumatic events that they themselves did not actually experience. The term is used . . . in both its narrow and broad sense. In the narrow sense, it refers to the transmission of nightmares, intrusive thoughts, flashbacks, and other symptoms typically experienced by traumatized individuals, to persons close to them. In the broad sense, it refers to any transmission of distress from someone who experienced a trauma to those around him or her and includes a wide range of manifestations of distress in addition to those that mimic post-traumatic stress disorder (PTSD) (Galovski & Lyons, 2004)” [Source: Dr. Rachel Dekel & Dr. Zahara Solomon, “Secondary Traumatization Among Wives of War Veterans with PTSD.” Article in Dr. Charles R. Figley and Dr. William P. Nash, *Combat Stress Injury* (New York: Routledge, 2007). p. 138.]
- “Compassion fatigue is defined as a state of exhaustion and dysfunction – biologically, psychologically and socially – as a result of prolonged exposure to compassion stress and all that it evokes. Prolonged exposure means an ongoing sense of responsibility for the care of the sufferer and the suffering, over a protracted period of time. The sense of prolonged exposure is associated with a lack of relief from the burdens of responsibility, the inability to reduce the compassion stress. Moreover, traumatic recollections are provoked by compassion stress and prolonged exposure. These recollections are of traumatic memories that stimulate the symptoms of PTSD and associated reaction, such as depression and generalized anxiety. Compassion Fatigue is inevitable if, added to these three factors, the helper experiences an inordinate amount of life disruption as a function of illness or a change in lifestyle, social status, or professional or personal responsibilities. [Dr. Charles R. Figley (Ed.), *Compassion Fatigue – Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York: Brunner-Routledge, 1995). p. 253.]
- The Center for Deployment Psychology (American Psychological Association) calls Secondary Trauma “Contagious PTSD” [Source: PowerPoint Presentation: “Families in the Wake of Trauma” found at <http://deploymentpsych.org/CDPpresDaveFamiliesandPTSD.ppt>.]
- “One of the really curious aspects of traumatization is that its symptoms are communicable. If you're intimately involved with someone who's been traumatized, you can literally pick up her symptoms. [For instance:] . . . family members . . . can pick up emotional numbing as a way of coping with the same disturbing symptom in their loved one. And once you're emotionally numb yourself,

you're subject to feeling depressed just like your loved one and to resort to similar mechanisms to combat emotional numbing. These may include sensation-seeking life-styles or an addictive and excessive pursuit of eating, drinking, drugs, gambling or sex." [Source: Dr. Don R. Catherall, *Back From the Brink: A Family Guide to Overcoming Traumatic Stress* (New York: Bantam Books, 1992). p. 69.

When a person experiences direct trauma as a result of his/her spousal relationship, the resultant condition is called *Primary Traumatic Stress*.

Adjustment Disorders. Can be triggered by a stressor of any severity, may be single or multiple events, may be recurrent or continuous events. These stressors elicit marked distress that exceeds what would normally be expected and significantly impairs social or occupational functioning (*DSM-IV-TR*, p. 679-683). Any person could supply this level of stressor to his/her spouse – especially someone suffering from PTSD.

Acute Stress Disorder/PTSD. The development of these disorders follow exposure to an extreme traumatic stressor involving direct personal experience of an event (or witnessing one) that involves actual or threatened death or serious injury or other threat to one's physical integrity. These stressors elicit emotions of intense fear, helplessness or horror (*DSM-IV-TR*, p. 463-468). A few examples of these stressors in a spousal relationship include:

- Physical/sexual abuse
- Physical/sexual abuse of children
- Threatening with a weapon
- Discharging a weapon in the house
- Rage
- Yelling, screaming
- Verbal abuse
- Threatening posturing
- Throwing objects
- Reckless driving
- Suicide threats, attempts
- Threat of abandonment
- Abandonment
- Fear of being killed while sleeping
- Dissociative episode (when spouse is thought to be the enemy)
- Waking up while being attacked by spouse
- Reactions to spouse's startle responses
- Reactions to spouse's paranoia
- Others

Unless the PTSD symptoms persist for a lifetime (whether they are from Primary or Secondary Traumatic Stress), there are two eventual outcomes: either the sufferer will experience some measure of healing, recovery and movement into a "new normal" and the consequent saving of the marriage, or it will end in separation (either emotional or literal) or divorce, and perhaps even in suicide or murder.

Other Terms that are also used in the context of Secondary Traumatic Stress which we won't be including in our communicating of the condition due to the complexity (and lack of agreement by professional as to their definitions in some cases):

- Secondary Traumatic Stress Disorder
- Primary Posttraumatic Stress Disorder
- Primary Stress Disorder
- Countertransference
- Vicarious Traumatization
- Emotional Contagion
- Burnout
- Secondary Victimization
- Pathological Empathy
- Co-victimization

¹ Regarding the term "normal" as it applies to COSR: in addition to the specific sentence quoted in the definition from USACHPPM above, this statement appears in a brochure entitled "Combat Operational Stress" put out by the Marine & Family Services, Naval Hospital, Camp Pendleton (Military One Source): "It is very common, in fact quite normal, for people to experience emotional aftershocks when they have witnessed highly stressful and life threatening situations."