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The Effects of Multiple Combat-Related Military Deployments on
Post Traumatic Stress Symptoms

Submitted by Joseph R. Hoops

May 14, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota. It is conducted within a nine month time frame to demonstrate facility with basic research methods. Students must individually conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

The purpose of this study was to learn the effects of multiple, combat-related military deployments upon post traumatic stress symptoms. This subject has particular importance given that the protracted conflicts in Iraq and Afghanistan have been fought by a military that is much smaller than in previous wars. A review of the literature showed that the effects of combat related deployments on post traumatic stress symptoms are significant. The impact is felt by both the veterans and their families. This has implications for clinical social workers working in systems that provide treatment and services for veterans and families affected.

This was a qualitative study. Interviews were conducted with seven subjects, all of whom are credentialed at the level of either Licensed Independent Clinical Social Worker or Licensed Psychologist. The interviews concerned the post traumatic stress symptoms of those clients for whom each clinician has provided treatment that has experienced multiple combat-related military deployments. The data was analyzed and four themes were noted with respect to the effect of multiple deployments on post traumatic stress symptoms: 1) effect on emotional arousal, 2) distinguishing aspects of multiple deployments, 3) effect on relationships and 4) self-destructive behavior. Issues of dysregulation of emotional arousal and negative impact on families also emerged in the literature review.

Acknowledgments

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The phenomenon of multiple deployments among armed forces personnel is fairly unique to the most recent conflicts in Afghanistan and Iraq. The impact of multiple deployments upon common mental health outcomes such as Post Traumatic Stress Disorder (PTSD) for affected military personnel is presently unknown. The intent of the present study is to examine the effects of recurring combat deployments upon post traumatic stress symptoms.

The experience of the men and women in the contemporary military is one of long and repeated deployments in conditions in which direct exposure to combat is common (Hosek, Kavanagh and Miller, 2006). The United States military forces are currently comprised entirely of volunteers. A reduction of approximately one third of active duty troops, from 2.1 million to 1.4 million, has occurred since the end of the cold war (Hosek, Kavanagh and Miller, 2006). Combat operations have been and continue to be conducted in Iraq, Afghanistan and, to a much smaller degree, Libya. The conflict in Iraq is now in its ninth year. These factors have combined to place an immense strain on both the physical and mental health of the men and women currently enlisted in the armed forces.

Among the common psychic wounds incurred by military personnel with direct exposure to combat are those associated with Post Traumatic Stress Disorder (Fear, et al., 2006). This study seeks to answer the question of what impacts multiple military deployments have upon post traumatic stress symptoms.

The trend toward multiple deployments has created circumstances in which military personnel may experience direct exposures to traumatic events in greater numbers than their historical counterparts. There may be grave consequences to the mental health of soldiers who have served in these circumstances. Specifically, an entire generation of combat veterans may

return from active duty with more severe post traumatic stress symptoms than has heretofore been encountered.

The implications for society are significant. McFarlane and Van der Kolk (2006) observed that society tends to respond to traumatized people with “conservative impulses in the service of maintaining the belief that the world is essentially just, that ‘good’ people are in charge of their lives and that bad things only happen to ‘bad’ people” (p. 28). They further argue that the presence of pain and suffering in human experience is more easily ignored by the larger society if those of its members who have experienced trauma are ignored. One is reminded of the contempt with which veterans of the Vietnam War were greeted upon their reintegration into society.

Kessler (2000) discussed the severe impairments associated with PTSD and its costs to society. Individuals affected by post traumatic stress are often unable to fully accomplish their goals with respect to education, relationships and career. This in turn impacts the ability of the trauma survivor to contribute to society and may in some cases result in utilization of publicly funded services. There are public health concerns as well. Psychiatric hospitalizations and suicide attempts occur with greater frequency among individuals with PTSD.

The impact on the families of military personnel affected by post traumatic stress must also be considered. In their review of the literature, Galovski and Lyons (2004) noted that PTSD is the critical mediating element in the development of the emotional difficulties that cause damage to family relationships. In their study, Sayers, Farrow, Ross and Oslin (2009) found “robust associations of a range of family problems with psychiatric distress in a cohort of relatively healthy, recent military veterans referred for mental health evaluation” (pp. 168-169). Role related adjustment difficulties were noted, for example, with 25% of the respondents

reporting that their children were either afraid of them or did not behave warmly toward them. In addition, relatively high rates of domestic violence, over 50%, were reported.

There are a number of possible implications for clinical social workers who work with military personnel who have experienced multiple deployments. Social workers in those settings will need to have a strong familiarity with post traumatic stress symptoms and be skilled in making accurate assessments. It will be necessary to be accomplished at clinical practices for which empirical data demonstrates effectiveness in treating those symptoms. There will further be a need for clinical social workers to keep apprised of emerging behavioral technologies that show promise in the efficacious treatment of post traumatic stress symptoms.

This study examined the severity of the post traumatic stress symptoms experienced by the current and former military personnel who have been deployed in combat-related situations in the conflicts in which the United States Armed Forces is presently involved. The impact of multiple, direct combat deployments upon post traumatic stress symptoms was investigated. The experience of post traumatic stress symptoms on affected military personnel was examined from the perspective of the clinicians that provide care and treatment.

Literature Review

The United States Armed Forces have been engaged in military operations in both Afghanistan and Iraq since the start of Operation Iraqi Freedom in March 2003. Two factors, the sheer length of these two wars, as well as the staggering numbers of troops deployed, over 180,000 in late 2007 and again in late 2009, have created circumstances in which multiple deployments of individual soldiers are common. In this context, the potential exists for recent combat veterans to experience more severe post traumatic stress symptoms than those experienced by earlier generations.

Combat experience and post traumatic stress disorder

The association between direct exposure to combat conditions and post traumatic stress symptoms has been well established. The National Vietnam Veteran's Readjustment Study (NVVRS), conducted in 1990, estimated that the lifetime prevalence of full PTSD is 30.9% among male theater veterans and 26.9% among female theater veterans (Weiss et al., 1992). In a study by Seal, Metzler, Gima, Bertenthal, Maquen and Marmar (2009), a diagnosis of posttraumatic stress disorder was made for 21.8% of veterans of deployments to Iraq and Afghanistan.

Etiology of Post Traumatic Stress Disorder

An event that carries a tangible threat of serious injury or death to one's self or others can potentially evoke a strong response of fear in the affected individual and produce in that person a perception of inescapable vulnerability (Yehuda, 2002). An event that elicits a response of this nature can be characterized as traumatic. Among the disorders that result from exposure to traumatic events are depression, anxiety, substance misuse and PTSD.

In a meta-analysis, Ozer, Best, Lipsey and Weiss (2003) found that a number of factors were predictive of PTSD and its associated symptoms for an individual exposed to a traumatic event. The factors delineated by the authors include prior experiences of trauma, prior psychological adjustment, the historical presence of psychopathology in the affected soldier's family, the perception of an actual threat to life, the emotional responses that occur simultaneously with the traumatic event, an episode of dissociation that occurs simultaneously with the event as well as social support following the trauma.

Bisson (2007) observed that the predictive factors for PTSD occur prior to, concurrent with and following the traumatic event. He noted that the severity of the traumatic event is a factor in the development of PTSD as well.

Dissociative responses that occur contemporaneously with the traumatic event are referred to as peritraumatic dissociation (Briere, Scott & Weathers, 2005). There appears to be an emerging consensus that peritraumatic dissociation is a particularly strong predictor of PTSD. Related to this, Birmes, et al., (2003), found that peritraumatic dissociation and acute stress symptoms are particularly strong predictors of PTSD. Gershunya, Cloitre and Otto (2001) found that participants who reported a greater degree of peritraumatic dissociation also endorsed levels of PTSD symptoms that were comparatively higher.

Clinical Presentation of Post Traumatic Stress Disorder

The criteria for a diagnosis of PTSD include an experience of fear, helplessness or horror in response to an exposure to a traumatic event and sequelae manifested subsequently that can be grouped in three separate clusters (Davidson et al., 1996). The first of these is a re-experiencing of the event in the form of nightmares, flashbacks and intrusive thoughts. The second is avoidance of stimuli that trigger memories of the event as well as a deadening of emotional responsiveness. The third is hyperarousal that persists in the form of hypervigilance and exaggerated startle response for a period no less than one month.

There is a full spectrum of functional impairments that sometimes manifest in PTSD. These include a reduced sense of well-being, diminished physical health, inability to perform physical tasks, a greater proclivity to violence, and current unemployment (Zatzick et al., 1997). There are pathophysiologic changes associated with PTSD as well. These result from the complex transaction between factors related to the traumatic event and the neurobiological and

psychosocial predisposition of the affected individual with respect to his or her ability to regulate distress (Connor & Butterfield, 2003).

Cumulative effects of trauma

There appears to be relatively little research concerning the cumulative effects of trauma on military personnel. There is evidence that multiple trauma exposures of a sexual and physical nature results in more severe post traumatic stress symptoms in children and adults. It may be possible to draw some inferences about the cumulative effect of multiple combat-related exposures to trauma by examining this data.

In their study of the impact of child sexual abuse, adult sexual assault, and spousal abuse, Follette, Polusny, Bechtle, and Naugle (1996) found that interpersonal trauma seems to have a cumulative effect. A study by Cloitre et al. (2009) showed a marked association between cumulative trauma and the complexity of the symptom presentation. It should be noted, however, that this association was present only in subjects for whom there was a common experience of childhood trauma. Two findings by Green et al. (2000) appear significant with respect to this issue. First, individuals who have had multiple exposures to traumatic events have more significant mental health symptoms than those who have had single or no exposures. Second, the experience of interpersonal trauma, particularly multiple traumas, is associated with greater distress than that of non-interpersonal trauma.

Deployment patterns in Iraq and Afghanistan

The military conflicts in Iraq and Afghanistan are distinguished from prior conflicts in that they are extended conflicts being fought by a military force comprised entirely of volunteers (Tanielian & Jaycox, 2008). It can be argued that the U.S. Military is simply not equipped in terms of size, resources or construction to function in protracted engagement on two fronts. In

this context, deployments have been of longer duration than intended; some units have been deployed for fifteen months. In addition, multiple deployments in combat situations have been widespread and intervals away from combat amid deployments have been sporadic (Hosek, Kavanagh and Miller, 2006). One-third of the 1.5 million active-duty and reserve soldiers who have been deployed since the events of September 11, 2001 have served a minimum of two tours in a combat zone (Johnson et al., 2007). Of that number, 70,000 have had three deployments, and 20,000 have had five deployments.

Multiple combat deployments and post traumatic stress symptoms

There are many allusions in the literature to the likelihood that multiple combat deployments are likely to affect the severity of post traumatic stress symptoms. There appears to be little empirical data to support this, however. This phenomenon does not appear to have been the subject of much study to date.

Of the studies this researcher examined, only one, by Fear et al., (2010), noted no association between mental health disorders and multiple deployments. The other studies reviewed by this researcher showed that there is an association present. Reger, Gahm, Swanson and Duma (2009) found, for example, that in screening military personnel for PTSD, those who had experienced two deployments were more likely to screen positive for PTSD. A report published by The Mental Health Advisory Team (MHAT) of the United States Army stated, in fact, that military personnel who had been deployed three or four times were at significantly higher risk for mental health problems than those who had been deployed one or two times (MHAT V, 2008).

Utilization of VA mental health services by veterans of combat in Iraq

A substantially greater number of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans entered the Veterans Administration (VA) system with mental health difficulties than OEF veterans that entered the VA system following the start of operations in Afghanistan (Seal, Metzler, Gima, Bertenthal, Maquen and Marmar, 2009). At this point the reasons for this are unclear. The rather meager data concerning the effect of multiple deployments on post traumatic stress symptoms appear inconclusive. These data, however, strongly suggest a need for further study.

Implications for Clients

A body of literature is developing to support the theoretical construction of a complex form of PTSD that occurs in trauma survivors who have had recurrent exposures to trauma over a prolonged period of time (Herman, 1992). This particular array of symptoms, also sometimes referred to as disorders of extreme stress not otherwise specified (DESNOS), is characterized by changes in six distinct areas of difficulty associated with early interpersonal trauma (van der Kolk, 2005). The first of these is the ability to effectively regulate affect. In specific, anger is modulated poorly and there are self-destructive behaviors such as self-inflicted tissue damage, disordered eating and substance misuse. Second is a diminished ability to focus attention and consciousness that affects memory and can contribute to dissociative episodes. Third are distortions in self-perception, such as a persistent sense of unfounded shame. Fourth are deficits in the ability of the trauma survivor to relate to others in a manner favorable to the development of trust and intimacy. Fifth is somatization, a tendency to experience physical symptoms for which there is not an apparent medical explanation. Finally is a loss of the belief systems that sustain the affected individual.

Herman (1992) conceptualized complex PTSD in a slightly different way. She identified three areas of disturbance that rise to a different level than simple PTSD. First, the symptom profile appears more complicated, heterogeneous and persistent. Second, the affected individual develops changes in personality. Third, trauma survivors exhibiting complex PTSD exhibit a distinct vulnerability to harm.

It is Herman's perspective that Complex PTSD is most likely to manifest in survivors of captivity or repeated childhood sexual abuse (Herman, 1992). The rationale for this is that vulnerability to Complex PTSD can occur only in circumstances in which the trauma survivor is prevented from removing him or herself from the perpetrator or perpetrators.

It is reasonable to consider, however, whether there are parallels between the experience of being held captive and that of being deployed in a situation in which there is direct exposure to combat. A soldier deployed thousands of miles from home in dangerous circumstances is not in a practical position to extricate him or herself. The soldier is also beholden to his or her superiors and, ultimately, to his or her branch of the service. The penalties for desertion are grave. If there are, in fact, certain parallels between these different types of exposure to traumatic stress, a sound argument can be made that combat veterans have a similar vulnerability to Complex PTSD.

Jongedyk, Carlier, Schreuder and Gersons (1996) conducted a study of 28 World War II veterans presenting at a national institute for treatment of Dutch war veterans and their children between January and October 1992. The results were in no way generalizable as the sample was not sufficient in size. The study nonetheless yielded some interesting results. Although this group of veterans was 45 years removed from combat experience, 67% met diagnostic criteria for PTSD. Thirty-eight percent of this group met criteria for DESNOS.

The potential implications for combat veterans who experience severe post traumatic stress symptoms are many. In van der Kolk's construction, severe difficulty in regulating affect can impact negatively on the veteran's quality of life as well as his or her relationships. Attentional difficulties can be an impediment to learning and employment and thus complicate the veteran's reintegration into his or her community. Dissociative episodes create significant safety issues for the affected individual as well as those with whom he or she comes into contact. Relational difficulties impact on the veteran's ability to avail him or herself of his or her support system upon return from active duty.

Implications for families

The difficulties associated with severe post traumatic stress symptoms may also have adverse effects on the family of returning veterans. Galovsky and Lyons (2004) noted that there is clear evidence in the literature that when PTSD is the result of exposure to violence in combat situations, the impact on the significant people in his or her life is dramatic. In a 1992 study of Vietnam veterans with PTSD, Jordan et al. demonstrated that serious difficulties were perceived in the family by both the veteran with PTSD and his or her spouse. These included violence, high levels of generalized distress, and behavior problems among their children. It was also noted that a pattern of violent behavior on the part of the veteran was in some cases reciprocated by the partner or spouse. Lester et al., (2010) found that roughly one-third of the children impacted by parental military deployments presented with clinically significant anxiety symptoms. Additionally, there was an increased risk of depression in children associated with the cumulative duration of parental deployments during the lifetime of the child.

Implications for Social Workers

There are broad implications for social workers. First, it is incumbent upon social workers across many settings to inform themselves about the impact of multiple deployments of upon post traumatic stress symptoms. It is of particular importance that social workers be well acquainted with the many and varied symptoms that manifest with this disorder. This will equip social workers with the ability to accurately assess psychological pathology in the combat veterans encountered in their practice.

Many of the affected soldiers will undoubtedly seek help from the Veteran's Administration, which will impact social workers in that setting. The nature of post traumatic stress symptoms, however, is that an individual may experience them without a conscious awareness of this. Those affected are thus likely to present in a number of different settings. Some combat veterans may experience somatic concerns related to post traumatic stress symptoms that bring them to clinics and hospitals to seek diagnosis.

There is evidence that a high prevalence of PTSD (12%-13%) manifests in the 3-4 months immediately following veterans' arrival home (Hoge et al., 2007). Social workers must be vigilant about returning veterans' mental health and functioning during that time period.

Social workers in school systems may recognize emotional problems or, possibly, symptoms of abuse in students whose parents are affected by post traumatic stress symptoms. Child welfare workers may similarly find themselves working with families in which abuse has occurred due to a parent's symptoms of post traumatic stress. Social workers across these settings must be alert to the manifold ways in which post traumatic stress manifests.

It is also important that social workers practicing in clinical settings are adequately trained in the effective behavioral and pharmacological technologies available to combat veterans with post traumatic stress symptoms. A social worker in these settings is in a vital

position; it is his or her charge to provide effective psychotherapy to affected veterans. It is also essential that referrals be made for pharmacotherapy and other services as indicated.

There are implications for social workers in academic settings as well. There is relatively little empirical data concerning the impact of multiple deployments upon the severity of post traumatic stress symptoms. The mantle thus falls to the social workers at colleges and universities to conduct further study. The development of clinical coursework specific to combat related post traumatic stress symptoms is indicated as well.

Research Question

What are the effects of multiple, combat-related military deployments upon post traumatic stress symptoms?

Conceptual Framework

This study aimed to determine the effects of multiple combat deployments on the severity of post traumatic stress symptoms. The applicable diagnostic criteria in the DSM-IV could have provided a framework with which to determine the severity of any psychiatric disorder relative to etiologic factors. There were many difficulties with this approach with respect to Post Traumatic Stress Disorder (PTSD), however. First, as is the case with any psychiatric diagnosis, PTSD exists essentially as a construction of certain patterns of behavior and internal processes that, although well considered, is ultimately a product of the limited powers of human discernment. Second, PTSD is a relatively new diagnosis that has evolved rather substantially in a short period of time. Third, an aspect unique to PTSD is that a key diagnostic criterion, Criterion A, considers two dimensions of the causative agent, the traumatic stressor. These include the properties of the stressor itself as well as the trauma survivor's appraisal of it. Finally, and particularly problematic for this study, a separate diagnosis has not yet been established for

complex PTSD. The symptoms of Disorders of Extreme Stress Not Otherwise Specified (DESNOS) are currently included under the DSM-IV rubric of “associated and descriptive features” of PTSD (van der Kolk, 2005).

The present study utilized the Diagnostic and Statistical Manual (DSM) symptoms for DESNOS as a framework. It should be noted that the DESNOS symptoms noted in the DSM are the product of research, conducted largely by Bessel van der Kolk and Judith Herman. Both had theorized prior to this that a more severe or complex presentation of post traumatic stress symptoms exists than is described for PTSD in the DSM for individuals who had been exposed to recurrent, severe trauma.

PTSD was recognized as a distinct mental disorder with the publication of the third edition of the DSM in 1980. Hundreds of thousands of Vietnam veterans returned from the war and exhibited psychiatric symptoms that were not suggestive of an existing disorder (van der Kolk, 2002). PTSD was established as a diagnostic category that incorporated the effects of traumatization on psychopathology.

The initial formulation of diagnostic criteria for PTSD was guided by a meager literature concerning what were at that time termed traumatic neuroses. In preparation for the third edition of the DSM, the DSM committee integrated clinical descriptions of traumatic war neuroses developed by Kardiner (1941), Horowitz’s research concerning the biphasic stress response (Horowitz, Wilner, & Kaltreider, 1980), and a few small studies of predominantly male burn victims (Andreasen & Norris, 1972) and Vietnam veterans (Shatan, Smith, & Haley, 1976) in order to construct diagnostic criteria.

As noted, one of the key criterion in making a diagnosis of PTSD, Criterion A, relates to the etiologic agent, the traumatic stressor. A diagnosis of PTSD cannot in fact be made unless

the traumatic event that causes the post-traumatic symptoms meets certain criteria delineated in the DSM. The DSM criteria for PTSD have evolved with the last three editions of the manual. It was specified in the DSM-III that the nature of the traumatic event must be such that it would cause "significant symptoms of distress in almost anyone" (American Psychiatric Association, 1980). The most significant modifications in the DSM III-R criteria were that the traumatic event must be "outside the range of usual human experience" and "markedly distressing to almost anyone" (American Psychiatric Association, 1987, pp. 247-248). It was further specified that the victim respond with "intense fear, terror, and helplessness" (American Psychiatric Association, 1987, pp. 247-248). There is a distinct departure in the conceptualization of the PTSD stressor in the DSM IV in comparison to earlier editions (Breslau & Kessler, 2001). There are two components to the definition. In part A1, a much broader range of qualifying stressors is outlined. In part A2, there is a requirement that the response to the traumatic event be characterized as intense fear, helplessness, or horror. This definition reflects an understanding that people have different responses to traumatic events that appear similar.

Van der Kolk has historically argued that the traditional construction of PTSD encompasses a very limited array of the trauma related symptoms, and that its focus is very strongly upon the pathology that occurs in children (Van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). It has been his contention that while the incidence of posttraumatic symptoms that do not fit within the diagnosis of PTSD is fairly universal, symptoms associated with childhood and persistent traumas have not been investigated to a significant degree. The tendency among researchers has been to refer to symptoms that do not fit the framework of PTSD as comorbid conditions. As a result there has been no meaningful way to measure such symptoms. Any effort to provide treatment would thus have been inexact.

Herman also found in her review of the literature that there is considerable empirical data to support the conceptualization of complex post-traumatic syndrome in survivors of persistent, recurring victimization (Herman, 1992). She further argues that it is the inability of both society and the mental health profession to recognize this syndrome as the inevitable result of long-term, persistent trauma that results in a generally poor understanding of trauma survivors. It is perhaps for this reason that the societal perception of individuals who have experienced chronic trauma tends to be unfavorable. Trauma related diagnoses tend to be viewed pejoratively, even within the mental health profession.

An attempt was made to address these concerns in preparation for the fourth edition of the DSM (van der Kolk et al., 2005). Specifically, a field trial for PTSD was conducted from 1990 to 1992. The purpose was twofold. The first priority was to develop a more precise definition of the A criterion and ensure that differing PTSD symptoms were grouped in applicable symptom clusters (Kilpatrick et al., 1997). Second was to examine whether a diagnosis of PTSD was applicable to individuals who had experienced long term interpersonal trauma or whether a different grouping of symptoms would more accurately describe their psychopathology. In the course of this study, a separate rubric was developed, as noted, for the symptoms most frequently identified that came to be known as disorders of extreme stress not otherwise specified or DESNOS (Herman, 1992).

The field trial yielded a number of important findings. First, interpersonal traumatization that occurs early in the trauma survivor's life results in more complex posttraumatic symptoms than interpersonal traumatization that occurs later in life (van der Kolk et al., 2005). Second, these symptoms tend to co-occur with PTSD symptoms and thus may not necessarily comprise a separate symptom cluster. Third, the likelihood that the DESNOS cluster of symptoms will

manifest increases diametrically with the age at which the trauma begins. Fourth, and perhaps most pertinent to the present study, the longer the duration of exposure to trauma, the greater the likelihood is that both PTSD and DESNOS will develop. Finally, DESNOS symptoms may provide greater impetus to seek treatment than PTSD symptoms. Although there was approximately the same prevalence of PTSD symptoms among both the community sample and treatment seeking sample in the field trial, virtually half of the sample seeking treatment met diagnostic criteria for DESNOS.

This study will utilize as its framework the six domains of functioning identified by DSM-IV PTSD task force as “necessary for the diagnosis of DESNOS: (1) regulation of affect and impulses; (2) attention or consciousness; (3) self-perception; (4) interpersonal relationships; (5) somatization; and (6) systems of meaning” (Zucker, Spinazzola, Blaustein & van der Kolk, 2006, pp. 21-22). In their work related to complex PTSD or DESNOS, as it has come to be called, Van der Kolk and Herman have focused primarily upon the phenomenon of long-term, persistent trauma in childhood. There has been very little study on the effects of long-term, persistent trauma that is experienced in adulthood. This is potentially the experience of military personnel who are deployed in combat situations on multiple occasions. This study aims to determine the effects of multiple combat deployments upon post traumatic stress symptoms. The six domains used to make a diagnosis of DESNOS provide a good template for determining the degree of dysfunction among veterans of multiple combat deployments.

Methods

Design

This was an exploratory qualitative study. The data were taken from in-person interviews with clinicians who work with military personnel who have experienced multiple deployments

with direct exposure to combat. The research question was: what are the effects of multiple military deployments involving direct exposure to combat upon post traumatic stress symptoms?

Sampling

In order to obtain data concerning the effect of multiple combat deployments upon Post Traumatic Stress Disorder (PTSD) symptoms, an interview was conducted with seven clinicians who work in a PTSD clinic at a large institution that provides services for veterans. Each clinician was chosen on the basis two factors. The first of these was that he or she be licensed either as a medical doctor, licensed independent clinical social worker (LICSW) or licensed psychologist (LP). The second was that he or she has direct experience working with military personnel who have experienced multiple deployments involving direct exposure to combat.

Protection of Human Subjects

Prior to the interview, the respondents were provided with a consent form that is approved by the University of St. Thomas/St. Catherine University Institutional Review Board (IRB) in order to ensure adequate protections were in place to prevent negative consequences to the respondent (see Appendix A). The consent form discussed the specific steps that would be taken to protect respondents from harm, including clarification regarding the matters of confidentiality and anonymity. In addition, the questions did not address issues that might have been emotionally painful for the respondents. The respondents were de-identified. The data will be destroyed following its use for this research. At no point study did the researcher have knowledge of the names of any clients being treated by the involved clinicians.

Data Collection

After selecting the respondents, an individual interview was conducted with each of them. The interviews were approximately 30 minutes in length. Each interview was recorded

for the purpose of making a written transcription. The first three questions were relatively closed-ended and sought primarily to establish the respondent's credentials as well as his or her experience working with military personnel who have experienced multiple combat deployments. The remaining questions were open-ended. The focus of the open ended questions was upon the clinician's assessment of client functioning relative to the six domains associated with DESNOS as well as how specific areas of functioning are affected. These six domains include (1) regulation of affect and impulses; (2) attention or consciousness; (3) self-perception; (4) interpersonal relationships; (5) somatization; and (6) systems of meaning. The entire interview will be transcribed for the purpose of conducting an analysis of the data.

Analysis Technique

A qualitative coding strategy called content analysis was applied to the data. Content analysis is a process in which themes, patterns, biases and meanings are extracted from qualitative data via careful, detailed and methodical examination and interpretation (Berg, 2008). The interview transcripts were subjected to careful review to identify codes and themes. A code refers to a particular pattern in the data. A theme is identified when three or more of a particular code is located in the data. Codes and themes were developed via grounded theory method. This consists of proceeding from specific data in the interview to more global themes. Every line of the data was examined in a process referred to as open coding in order to identify similarities and differences. The themes most salient to the research question were then culled from those identified via content analysis.

Limitations and advantages

One clear limitation is that while common themes will likely emerge from the data, the definition of specific terminology tends to be unique to the individual. Each clinician

interviewed may thus apply terminology in a slightly different manner. This may impact on reliability. Validity can also be an issue in the application of content analysis (Monette, Sullivan & DeJong, 2008). It is critical that coding schemes be developed that are valid indicators of what this study seeks to measure, in this case signs and symptoms of post traumatic stress. However, it is essential that the coding categories developed be defined clearly and objectively. It should also be noted that there is no objective means via which all of the dimensions of qualitative data can be adequately measured.

As with most qualitative studies, the number of participants is relatively small and non-randomly selected. The study thus has low generalizability.

One advantage is that themes were extracted directly from the data. This ensured greater validity than a more arbitrary approach such as imposing categories upon the data that have been developed independent of it. This also created the potential for themes to be identified that had not been anticipated by the researcher. Content analysis can potentially capture data related to the overall presentation of those being interviewed, such as emotional state and tone of voice, which may be relevant to the overall study. Another advantage is that themes identified may provide direction for future research (Kolbe & Burnett, 1991).

Participants

Seven clinicians were interviewed for the purpose of this study. One was female. Six were male. One was African American. The other six were Caucasian. Five held Master's level degrees in Social Work. Of these, three were credentialed as Licensed Independent Clinical Social Workers. Two were PhD level psychologists. All were employed by a department of the federal government that provides services for veterans of the armed forces. Five had specialized training in providing treatment for Post Traumatic Stress Disorder such as prolonged exposure

and cognitive processing therapy. All provided outpatient services to veterans of multiple combat related military deployments.

Findings

This study sought to investigate the effects of multiple, combat-related military deployments upon post traumatic stress symptoms. The findings were developed from interviews with seven clinicians who provide treatment for veterans of two or more deployments in direct combat situations. Six of the interviews were conducted face to face and one via telephone. Of the face to face interviews, four occurred in the clinician's office with the door closed. One interview was conducted in a meeting room with the door closed. One interview was conducted in a cafeteria. The intent was to conduct the interviews in the environment in which the respondent would be most comfortable and which would be relatively quiet and free of disruptions.

The themes that emerged from the interviews regarding the effect of multiple combat deployments on post traumatic stress symptoms fall into four categories, 1) effect on emotional arousal, 2) distinguishing aspects of multiple deployments, 3) effect on relationships and 4) self-destructive behavior. The themes are delineated below and are illustrated with excerpted comments from the qualitative data.

Effects on Emotional Arousal

Four distinct subcategories, each reflecting a particular arousal response, emerged with respect to effects of multiple deployments on emotional arousal. This array of arousal-related symptoms suggests that the effects of multiple deployments upon the internal mechanisms that trigger arousal responses may be fairly complex.

Persistent state of acute anxiety. One of the effects evident in the data upon post traumatic stress symptoms experienced by veterans of multiple combat deployments is an unremitting state of acute anxiety that permeates every aspect of his or her experience. The first two quotes reflect the chronicity of this condition in fairly straightforward terms:

- They're just so intense, all the time.
- They're constantly dealing with anxiety.

Another respondent noted the pervasiveness of anxiety among veterans being treated for post traumatic stress symptoms:

- They're all talking about anxiety.

Still another respondent had the perspective that anxiety and PTSD are essentially synonymous:

- If you're looking at the anxiety spectrum as part of mood disorder...anxiety is PTSD.

The researcher identified this as a very strong theme throughout the data. It reflects the persistence and intensity of emotional arousal for veterans of multiple combat deployments.

Hypervigilance. Another theme that emerged related to veterans' experience of arousal was an intractable state of hypervigilance. One respondent saw substantive differences between the nature of hypervigilance experienced by veterans of the Vietnam war as opposed to those of Operation Iraqi (OIF) Freedom/Operation Enduring Freedom (OEF). This respondent attributed this to the prevalence of improvised explosive devices (IEDs) in OIF/OEF:

- Because of that sense of danger, that they are constantly in danger, particularly for the OIF/OEF people vs. the earlier Vietnam veterans is the, you know the IEDs, I think, have done lots of damage to them since that. Uh...it's very difficult to drive for many of them, because they're constantly on the watch for IEDs.

The same respondent also stated there is tendency on the part of OIF/OEF veterans to continuously scan his or her field of vision:

- They're constantly...looking for snipers that of course aren't there.

Another respondent noted that relatively benign objects can be seen as potential threats through the prism of hypervigilance:

- ...civilians, we drive down the road all the time and we see a paper bag, a McDonald's bag, and we wouldn't think twice about it, but for them they're so used to looking at that and wondering , "is that a bomb?"

Allusions were made also to significant distortions in perception:

- People are always looking out for, or looking around them, they're looking out to get them...they see things out of the corner of their eye, but there's nothing there.

The phenomenon of hypervigilance was also seen as extending to interpersonal contact:

- ...it's that battle mind, umm...concept of, I'm constantly looking at my surroundings, I'm on guard, umm..., and I'm looking for everything that may be out of place, any kind of body language that's not going well.

The researcher identified hypervigilance also as a very strong theme. The data provided a fairly compelling sense of another aspect of the heightened arousal experienced by veterans of multiple deployments.

Anger. Another aspect of emotional arousal is anger. One respondent described the immediacy with which the anger response may manifest for veterans:

- Impulsive anger, I can say, is the most emotion that they do express...quickly, without hesitation...is anger.

Another respondent alluded also to the immediacy of the anger response, but suggested the context for this lies in the mundanities of life outside of the military:

- He's so easily irritated and pissed off by just the little, shallow things that he sees in civilian life.

One respondent characterized the anger response as a way that military personnel learn to cope with the anxiety that occurs in combat situations. The response becomes automatic. This becomes problematic when the automatic response to anxiety in civilian life is anger:

- ...what will oftentimes happen is, as their anxiety gets engaged...The coping response to deal with that anxiety would be to get angry. And so a lot, I think, have problems as a result with the anger...

One respondent simply noted the pervasiveness of anger issues for veterans of multiple deployments:

- I would say they have more issues of anger.

The researcher also identified anger as a strong theme; it was discussed by all but one of the clinicians interviewed.

Ability to Regulate Emotion. One of the defining characteristics of post traumatic stress is impairment in the ability to regulate emotion. This dysregulation manifests in both a lack of control, as well as an excessive degree of control, over emotions. One of the respondents referenced both aspects of emotional dysregulation:

- If you have PTSD one of the main things you've got is difficulty regulating emotions, particularly like anger and...anxiety, and usually people either shut down or have too much of it.

More than one respondent alluded to a tendency to lose control of anger. One touched on the occurrence of “road rage” three times during the interview. Another put it very simply:

- Anger becomes difficult to control.

A third respondent suggested that the tendency to suppress emotions is a form of dysregulation:

- They tend to get very restrictive with their emotions and by virtue of their success in restricting their emotions, you could say that they don’t have a problem regulating them...but I would say that they do have a problem regulating them in that they often feel as though...that it’s not safe or advisable to allow themselves to experience a full range of emotions.

The researcher identified emotional dysregulation as a very strong theme. As indicated in the foregoing, clinicians had varying perspectives as to what constitutes emotional dysregulation.

Detachment from Emotions. In contrast to the phenomenon of dysregulation is detachment from emotions. One respondent described this sense of detachment in straightforward terms:

- Someone with PTSD often feels very distant from their own emotions.

Another respondent described the phenomenon of emotional detachment as a response to combat:

- One of the other things that happens, I think, naturally in combat...you have to do this...is dull down your emotions... the way our emotions work, is we can’t choose certain emotions to shut down and not others.

The respondent suggests that this process of “shutting down” tends to generalize to other emotions. A third respondent touched on how this applies to positive emotions:

- They tend to be much more restrictive in their overall emotional expression, especially positive emotion...because they don't really feel much.

This theme was identified by the researcher as being moderately strong in the interviews with clinicians. It appears to illuminate a phenomenon that is separate from restriction of emotions, something more akin to an emotional numbness.

Distinguishing Aspects of Multiple Deployments

There were some allusions in the data to aspects of the distinctive impacts that multiple combat related deployments have on post traumatic stress symptoms. One respondent stated that while the symptoms of post traumatic stress for veterans of multiple deployments are not substantively different than for veterans of single deployments, the symptoms tend to be more severe. The severity of the symptoms creates more difficulty in their lives:

- What seems to be different is that it's more extreme, or the symptoms are more extreme, so there might be greater difficulty because the symptoms are higher.

A second respondent discussed the occurrence of avoidance symptoms common to PTSD in veterans of multiple deployments. This respondent had the perspective that veterans of multiple deployments are perhaps somewhat fatalistic about their avoidance:

- In terms of multiple tours are more likely to...avoid... the traditional ways that you see with PTSD...in such a way that they're not as bothered by their avoidance. They feel maybe more resigned to it.

This theme was not identified as a particularly strong theme by the researcher. These quotes do suggest a connection between the multiple deployments and the severity of symptoms.

Effect on Relationships

There are serious consequences to the important relationships of veterans of multiple deployments due to the post traumatic stress symptoms that occur in the context of those relationships. Six of the seven respondents discussed negative impacts on relationships. One respondent described a sense of alienation that underlies the distancing behavior in which the veteran engages in his or her personal relationships:

- Interpersonal relationships tend to be strained...either distancing from other people, snapping at other people, feeling very different from them.

A second respondent also touched on the isolating and distancing behaviors and the effect this has on the partner:

- So they isolate from other people and they feel lonely and it's a little confusing to the partners because this person the partner keeps trying to be close to keeps moving away from them in different ways.

A third respondent described a common dynamic in the way combat veterans push their partners away:

- They're deciding like, "well, if I be a real asshole to my wife, maybe she'll leave me the hell alone" ...so whether they mean to do it or not that tends to be what happens and that serves to kind of push them away.

A fourth anticipated a significant increase in conflicts between partners in the aftermath of multiple deployments:

- You're going to have lots more conflicts perhaps than you had before.

Another respondent noted the ambiguity that results for the partner when the combat veteran exhibits changes in his or her emotional responses and but is disinclined to discuss any of the experiences that caused these changes.

- Also, if you come back feeling like I've done things I don't want to discuss...and you're not discussing them with your spouse...then you're taking a very important part of your life and keeping it from the other person...and you're reacting in certain ways that can't be explained without talking about those things. And so when your spouse or anybody else close to you sees you behaving in a certain way and you can't or won't explain it...they might see at as "he doesn't care for me anymore, he isn't capable of caring for anybody anymore."

As this respondent suggests, this dynamic interferes with intimacy between partners.

Another respondent alluded to the range of consequences that can occur in a relationship when the negative effects of the veteran's combat experiences linger and manifest in the context of the relationship:

- They say war is hell, which of course it is, but when you come back from war, you bring hell with you. And that affects their interpersonal relationships. Divorce, ...separation...verbal abuse minimally.

The researcher identified this as a particularly strong theme. It is noted that the respondents focused fairly exclusively on primary relationships.

Self Destructive Behavior

The researcher noted a number of references in the data that suggested a proclivity to both substance misuse and high risk, thrill seeking behaviors on the part of veterans who had two or more deployments. Such behavior can be termed self-destructive as it puts the health and safety of the affected veteran at increased risk.

Substance misuse. Use of alcohol to a degree that impacts on a veteran's life is common. As one respondent noted:

- What I see is...alcohol problems.

Another respondent emphasized the extreme nature of use patterns:

- Substance...excess substance use...alcohol excess.

A third respondent characterized the misuse of illicit drugs as way of coping with post traumatic stress symptoms:

- The majority of them that I've been through, are abusing either pot or opiates as a way to kind of numb themselves out in many aspects so they're not recalling the faces of what their duties were in combat.

A fourth noted that internal resources become depleted as a result of post traumatic stress symptoms, and that, lacking internal reserves, veterans turn to substance misuse:

- The ones who develop PTSD... their resiliency is shaken to its core...to the extent that they have very little, and I think that explains a lot of the...substance abuse.

The researcher identified this theme to be at least moderately strong.

High risk behaviors. One respondent noted susceptibility on the part of veterans of multiple deployments to engage potentially hazardous behavior:

- Extreme behavior, problems with dangerous or risky behavior... sort of predisposition toward extreme activities.
- Another noted that this pattern tends to manifest in the context of operating a motor vehicle:
 - Driving recklessly or driving very defensively

A third respondent conceptualized this pattern of behavior as a way to stimulate adrenaline in a manner similar to what is experienced in combat:

- Sometimes they'll put themselves in high risk situations. They kind have that adrenaline kick that they don't get when they're not in combat. Sometimes I've met some people that need that adrenaline rush and sometimes they seek out...situations that aren't always the healthiest or the safest and get themselves into legal trouble.

A fourth respondent suggested that soldiers have an awareness of the secondary gain, the sense of exhilaration, experienced in combat similarly sees an effort on the part of some veterans to replicate this in civilian life:

- ...seeking thrills. Some people enjoy doing what they're doing. They know what it is. And they're going to continue with that when they come home.

This theme was identified as at least moderately strong by the researcher. The data suggest that the reasons for this pattern of behavior are particularly complex.

Discussion

Four clear themes concerning the effects of multiple deployments on post traumatic stress symptoms emerged from the data in this study. The specific themes identified are 1) effect on emotional arousal, 2) detachment from emotions, 3) effect on relationships 4) distinctive aspects of multiple deployments and 5) tendency toward self-destructive behavior.

With respect to the issue of emotional arousal, four subthemes were identified by the researcher, specifically, 1) acute and persistent anxiety, 2) hypervigilance, 3) anger and 4) difficulty regulating emotions. The first of these subthemes is one of the characteristic symptoms of post traumatic stress. It can be argued that this subtheme and the third, anger, have a relationship with exaggerated startle response, another classic symptom of post traumatic stress

disorder. The unyielding state of anxiety common to veterans of multiple deployments can easily be considered a natural precursor to the startle response. Anger could be interpreted as a manifestation of the startle response, and a likely alternative response in a soldier who is conditioned to respond aggressively to any stimulus that might appear to pose a threat. There were allusions in the data to the explosive nature of the anger that manifests in veterans of multiple deployments. This suggests an automatic emotional response akin to the startle response. Hypervigilance, the second subtheme noted, is another well recognized symptom of post traumatic stress. Some of the data illuminates the connection between the experiences of a soldier involved in armed combat and this particular symptom. The intractable nature of the veteran's state of hypervigilance described in the data mirrors the constant threat to one's safety, indeed one's life, in a combat-related deployment.

The fourth subtheme noted with respect to emotional arousal was difficulty regulating emotion. Emotional dysregulation is another symptom that is characteristically linked to post traumatic stress. The data in this study appears to diverge somewhat from commonly held views about dysregulation; conventional thought concerning this tends to center on a loss of control of emotional expression. Emotional responses are markedly disproportionate to the stimulus that precedes them. There is a disordered nature to the way these responses manifest. Minor annoyances may, for example, trigger agitation, verbal abuse or physical aggression. Any unexpected stimuli, however benign or unremarkable it may seem to the observer, may immediately result in an acute state of terror and watchfulness. There were also allusions in these data, however, to the idea that an excessive degree of control constitutes dysregulation. This is an argument that has some logical consistency, as over-control of emotion in some instances would constitute a maladaptive response in the mechanisms that trigger emotion. In

this construction, it may perhaps be useful to envision affect regulation as a phenomenon that occurs along a continuum from restriction of, to severe impairment in controlling, emotional expression. Affect dysregulation can be seen as the level of expression that occurs at the extreme ends of the continuum.

Another theme that emerged was detachment from emotions. This researcher conceptualizes emotional detachment as distinct from over-regulation of emotions. The latter can be seen as volitional in nature; emotions are experienced to some degree and are suppressed. Emotional detachment, on the other hand, can be seen as a condition in which these sensations are not consciously experienced. This phenomenon might be further characterized as a low grade occurrence of dissociation.

One theme that is directly pertinent to this study, but for which the evidence in the data was less compelling, relates to the unique aspects of the post traumatic stress symptoms experienced by veterans of multiple combat deployments. There were indications in the data that post traumatic stress symptoms are more severe, but not necessarily different. This is consistent with much of the literature on this subject. Given the implications for assessment and treatment of post traumatic stress, this theme is in the opinion of this researcher important enough to warrant further study.

One of the strongest themes to emerge was the negative impact on the relationships of those affected by post traumatic symptoms due to multiple deployments. It should be noted that the data related to this theme that emerged in this study apply almost exclusively to the primary, partner relationship of the affected veteran. Six of seven respondents referred directly to how primary relationships are affected. Conflicts are more frequent. The combat veteran often creates distance from his or her partner by actively withdrawing or by creating a sense of

alienation by engaging in aversive behavior. These dynamics create barriers to intimacy and the capacity of the veteran's partner to have empathy. This in turn creates more distance between the partners and both are left with a sense of increasing isolation.

A particularly severe presentation of post traumatic stress symptoms, given the attendant unpredictability of mood and behavior, brings an element of chaos to the primary relationship that may frequently have a destabilizing effect and which may damage the relationship over time. Although there were only two passing references to the effects of post traumatic stress symptoms upon relationships with children, it can be reasonably inferred that these destabilizing factors impact significantly on children. First, a chaotic home environment will directly affect a child's immediate well-being and long-term development. Second, chronic marital discord is likely to deplete both partners' internal resources and impact on the ability to parent effectively. It can also be inferred that the dynamics that emerge between the veteran and his or her partner will also occur between the veteran and his or her children. Finally, a child of any age has less capacity than an adult partner to understand the erratic behavior of a parent. It is thus likely that the effects the effects of the veteran's behavior upon relationships with children would be more severe. This is not evident in this study, however. More research is needed.

The occurrence of self-destructive behavior in the form of substance misuse and high risk acts such as reckless use of motor vehicles was another significant theme. This phenomenon was not reflected in the literature review. The potential impact of this affects not only the health and safety of the veteran, of course, but of those who come in contact with him or her.

It may be worth noting two themes that were not reflected in the data. First, symptoms that involve a re-experiencing of the traumatic event are an important element in the diagnostic profile of post traumatic stress. There were only passing allusions to this, however, in the data,

primarily in the context of some respondents' description of hypervigilance. Interestingly, not one respondent mentioned flashbacks. Only one mentioned nightmares. This may reveal limitations of the interview questions that the researcher developed for this study. Second, although this researcher suggests in the foregoing that emotional detachment may be on the same spectrum as dissociation, there were no direct references to dissociation on the part of any of the respondents.

Areas for Future Research

The data related to the cumulative effects of multiple deployments upon post traumatic stress symptoms were not particularly strong in this study. A quantitative study of the effects of multiple deployments may yield findings less ambiguous than those delineated here. There are a number of assessment tools that measure post traumatic stress symptoms that could be used as the basis for a study.

Military operations in Iraq are being brought to a close. The military remains engaged in Afghanistan. The impact of multiple deployments is in the very early stages of being felt. A longitudinal study of the effects of multiple deployments would thus be beneficial as well. There is at present no means of understanding the effects of multiple deployments upon a veteran over time.

Promising treatment models such as prolonged exposure and cognitive processing therapy are already being utilized in the treatment of post traumatic stress. It is important that the effectiveness of these models be studied. Such research may suggest modifications that increase effectiveness these existing models as well as to lay the foundation for the development of new models. It may also clarify the circumstances in which application of a particular model is indicated. Both the potential risk and benefit to the affected veteran of a specific modality of

treatment could be more carefully weighed before implementation. Some treatments, such as prolonged exposure are fairly invasive and should thus be applied judiciously and with indications grounded in research. Certain treatment models may be effective in treating veterans with a particular symptom profile and less so with others. Much of this could be clarified with research.

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APPENDIX A

**ST. CATHERINE UNIVERSITY AND
THE UNIVERSITY OF ST. THOMAS
MSW PROGRAM**

Request for Establishing MSW Clinical Research Committee

STUDENT NAME: Joseph R. Hoops **Student UST ID#** 100746718

I have discussed my research with and request that the following comprise my research committee

CHAIR:

Faculty Chair Signature

Date

COMMITTEE MEMBERS:

By signing below, committee members acknowledge their responsibility to, at minimum, meet as a committee once each semester, to read and comment on student's written work, to offer support and guidance throughout the research process and to attend the public presentation of the paper in May.

COMMITTEE MEMBER:

Jenny Jendro

Name **(Please Print)**

Signature

Date

Mailing Address of Committee member → Please print clearly:

2550 University Avenue, Suite 229N
St. Paul, MN 55114

Psychiatric Recovery
Institution/Agency

jenny@psychrecoveryinc.com

Email address to send Final Program and other communication – PLEASE PRINT clearly

COMMITTEE MEMBER:

Tamara Kincaid

Name **(Please Print)**

Signature

Date

Mailing Address of Committee member → Please print clearly:

412 W. Kinne St., PO Box 670
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Institution/Agency

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APPENDIX D

Submit to: Clinical Research Presentation coordinator SCB 201

Date Due: February 24, 2012

**Clinical Research Presentations
May 14, 2012
Student Agreement Form**

I.

Name: Joseph R. Hoops Date: February 12, 2012
(Please Print)

I intend to complete my clinical research paper [bound copies to MSW Program Manager by Friday May 11, 2012] and present it on May 14, 2012.

My official **title** for use on the workshop program is:

The Effect of Multiple Military Deployments on Post Traumatic Stress Symptoms

Please list my **name** this way on the brochure:

Joseph R. Hoops

I plan to use Power point for my presentation: x yes no

If I am unable to present I will notify my clinical research chair immediately. My chair will notify the workshop coordinator.

Student Signature _____ Date _____

II.

Chair Signature _____ Date _____

Appendix E

Research Interview Questions

I'd like to begin with some general information about your credentials and the nature of your work.

1. Please tell me your professional credentials.
2. Describe your training and experience and training in the treatment of post traumatic stress symptoms.

3. Do you work with military personnel who have been deployed in combat situations?

Now I have some questions about your clients.

4. Of those military personnel who have been deployed in combat situations, can you tell me the approximate percentage who have been deployed two or more times? To your knowledge, have multiple deployments become more commonplace since the start of the Iraq War in 2003?
5. Do you notice any patterns in the emotional states that you observe in veterans of multiple combat deployments typically experience? Do the veterans you treat mention certain emotional states mentioned more than others? Can you give me some examples? What emotional states do veterans describe during direct exposure to combat?
6. Do the veterans of multiple combat deployments have difficulty regulating emotions? How is behavior affected when this occurs?
7. How do veterans of multiple combat deployments function in their day to day lives? Are there common problems?

8. How are relationships affected?
9. Are veterans of multiple combat deployments aware of how their experiences affect their emotional states? Are they aware of how their behavior is affected?
10. Are they more likely to come to the Veterans Administration with physical or psychiatric concerns? Please explain.
11. Do the veterans experience any changes in their value system? Can you give me examples?
12. Do they discuss the effect of their experiences on spirituality? Please give me examples.