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CHAPTER 24

A Confluence of Crises: Migration, Anthropogenic Climate Change, Mass Casualties, War, and Civil Unrest

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CHAPTER OVERVIEW

The purpose of this chapter is to explore the confluence of crisis issues that relates to migration, anthropogenic climate change, war, and civil unrest. Such a confluence of crises is complex and involves interrelated situations that may result in humanitarian emergencies and mass casualties. Events of the 21st century have made clear how critical it is for counselors and other helping professionals to understand the convergences of these very real human-behavior-driven dynamics and to intercede, as necessary, in ways that are productive. The major objective of this chapter is to elucidate this crucial contemporary issue of multiple intersecting crises and trauma events.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Identify how intersecting mass crises and traumas affect individuals and communities;
2. Describe the dynamic interrelationships between and among crises and the influences that they have on one another;
3. Understand the nature of complex crises and the ecological effects that they have on individuals, from a holistic perspective; and,
4. Apply counseling techniques and public mental health strategies that are conducive to building both personal and community resilience and to assisting affected persons and communities in their recovery from complex crises.

INTRODUCTION AND CONTEXT

Traumatic events entail real or assumed threat, injury, or death to individuals, any of which may occur during a crisis. The term “crisis” often is embedded in the context of an individual experience—a crisis befalls one person or a family unit. However, crises also can happen on a much larger scale, in which even the helpers or first responders may be put into danger (Mathieu, 2012). These crises can be termed as complex humanitarian emergencies and may involve mass casualties. They can affect entire geographical areas and service sectors (e.g., water insecurity or drought due to climate change) or even, as in the case of a pandemic like COVID-19, the entire world (Ratha et al., 2020).

Unfortunately, there are often overlaps between and among crisis situations, with one exacerbating the effects of another. This is the essence of what is explored and explicated in this chapter. For example, climate change can lead to civil unrest due to a lack of essential resources for survival and a government’s inability to respond effectively. This schism, in turn, can lead to war, which may cause unrest and famine, and then the famine may lead to subsequent migration. When mass trauma strikes, the same situation may affect people differently or not at all, because distribution of resources is not equal. Furthermore, as an example, the unprecedented circumstances resulting from a pandemic like COVID-19 have catapulted counselors and helpers around the world into the same or similar trauma experiences as prospective clients. Other relevant present-day comparisons to such circumstances are nearly impossible to conceptualize on such a massive scale. In this type of scenario, trauma counselors are faced with the need for personal healing and the imperative to provide professional help simultaneously; counselors dealing with the same life-altering situation as clients is a novel phenomenon for modern times.

This chapter explores issues pertaining to migration, anthropogenic climate change, war, and civil unrest as a confluence of crises, that is, as complex and interrelated situations that are likely to result in humanitarian emergencies and mass casualties. It is crucial that counselors and other helping professionals understand the intersections of these very real human-behavior-driven dynamics; therefore, a major aim of this chapter is to illuminate this critical contemporary issue of multiple intersections related to trauma and crises. Relevant research and suggestions for clinical practice are provided in this chapter to aid counselors in addressing the complex crisis situations that represent the interrelationships among these various, and sometimes seemingly disparate, crises. The confluence of complex crisis situations is discussed in the following sections: Complex Crises and Migration, Complex Crises and Anthropogenic Climate Change, Complex Crises and Mass Casualties, Complex Crises and War and Conflict, Relevance of Intersecting Trauma and Complex Crises, Complex Crises and Social Justice, and Counseling Implications of Complex Crises. These discussions are followed by a summary of their intersections as well as an online section presenting useful resources related to this topic.

COMPLEX CRISES AND MIGRATION

The interconnected issues of immigration and trauma, along with constructs and social dynamics that have parallel similarities to migration, are detailed in Chapter 17. However, the focus on migration, in the current chapter, reflects the complex intersection of migration with other forces, which can result in a set of complex crises. In this section, we explore how traumatic experiences can lead to leaving one’s homeland, how trauma can occur during such a movement, the psychological effects of migration, and how migration intersects with other crises.

Leaving the Homeland

Migration is defined as traveling from one’s home or familiar geographical location to a new place, for a multitude of reasons. Frequently this entails crossing large distances with the

hope of better living circumstances. [Lévers and Hyatt-Burkhart \(2012\)](#) have suggested the potential for many types of migration-related traumatic experiences, even under more ideal migration circumstances. Reaching a decision to leave one's homeland permanently, in and of itself, can be a stressful event—even when the purpose for relocation is for a desired outcome, such as employment or schooling. However, when people are forced to make such high-stakes decisions, in the face of potentially life-threatening situations like war, famine, water-scarcity, and other imperiling conditions, the imminent sense of danger may be overwhelming. Deciding to leave, perhaps with only the clothes on their backs, may push people further toward the brinks of despair and trauma that these types of volatile circumstances already create. See the case illustration in [Box 24.1](#) for an example of why someone might be faced with making the decision to leave her homeland.

Complex crises and trauma certainly can lead people to choose to leave an area in mass numbers. As noted, reasons for a mass exodus may include war, poverty, climate change, civil unrest, and so forth, but unfortunately the trauma of the migration process itself often is overlooked, overshadowed by what people are trying to leave behind. In essence, the act of migration, in combination with the reasons for the migration, may create an exponential spiral of negative consequences and additional traumatic events. For example, during the last decade, we witnessed thousands of lives lost; migrants, fleeing their homelands due to a variety of complex crises, died trying to cross the Mediterranean Sea. Most were leaving the kinds of volatile situations that were previously described, but human ruthlessness also intersected with and contributed to these deaths; many of the migrants were exploited by those who monetized the need for emergency evacuation travel and sold transport on vessels known not to be seaworthy, while some other migrants became victims of human trafficking ([Galos, 2017](#)).

BOX 24.1

Case Illustration: Boipelo

Boipelo resides in a rural and remote area in an arid region of southern Africa, where she cares for her three children. After her partner was killed in a mining accident, she has even fewer resources to help sustain herself and her family, despite having other family members living in her village. With drinking water becoming more and more scarce, Boipelo is feeling a constant tension within herself and with the people around her, finding it hard to go about her daily responsibilities. The people in her community have been on edge for quite some time and have talked about leaving the area, but she is not sure how she could manage a long journey with three young children. There has been talk about neighboring groups coming to take what little resources this village still has. Feeling unsafe, with no time to grieve the loss of her partner, Boipelo faces a major life-altering decision with an uncertain future ahead of her. Does she make the decision to leave the only place she has ever known, to leave her rich culture and traditions? Alternatively, does she decide to stay and hope that her living circumstances will improve, even though the future looks bleak?

Reflection Questions

- What are some of the major issues that Boipelo faces, in both scenarios, of staying and of leaving?
- How do you think Boipelo is coping with her situation?
- What would be some adaptation mechanisms that Boipelo could enlist?
- How would you conceptualize Boipelo's situation if she came to discuss her circumstances with you?

Trauma During Migration

Trauma experienced prior to, during, and post migration can be detrimental to an individual's health and well-being ([Clemens et al., 2020](#); [Erazo, 2018](#); [Hanna & Oliva, 2016](#); [Larr & Neidell, 2016](#)). These experiences may include, but are not limited to, experiencing violence

as well as separation from family members. The latter garnered so much recent attention that the former president of the American Psychological Association (APA), Dr. Jessica Henderson Daniel, issued a statement asserting that separating families due to inadequate documentation is “needless and cruel,” and “threatens the mental and physical health of both the children and their caregivers” (APA, 2018, “Statement of APA President,” para. 2).

In response to family separation as a matter of policy, the United Nations (UN) began drafting the Global Compact for Safe, Orderly, and Regular Migration (Erazo, 2018; UN, 2018), which has outlined provisions for a smoother and safer migration experience. Objectives as well as actionable items related to pre, during, and post migration included the following: minimizing adverse drivers and structural factors that compel people to leave their country of origin, providing adequate and timely information at all stages of migration, addressing and reducing vulnerabilities in migration, facilitating fair and ethical recruitment and safeguarding conditions that ensure decent work, providing access to basic services for migrants, eliminating discrimination, and promoting fact-based public discourse to shape perceptions of migration (UN, 2018). This call to action has underscored how ubiquitous adverse experiences can be for migrants. The actionable items that were previously outlined can seem daunting, but are necessary because migrants’ mental health is affected by the complex array of traumatic experiences that can befall them at any stage of migration (Levers & Hyatt-Burkhart, 2012).

Psychological Effects of Migration

The APA has espoused an ecological approach to explaining the effects of migration on an individual, meaning that the environment prior to, during, and after migration affects people—as no one exists without context, without a personal ecology (APA, 2012). This effect of migration on an individual can be framed as a “psychopathology of the crossing,” which has entailed the relationship between mental health problems and the migration process, thus “shedding light on the multiplicity, complexity, and consequences of such traumas” (Cenat et al., 2020, p. 421). For example, traumatic consequences such as posttraumatic stress disorder (PTSD), anxiety, depression, deteriorating physical health, and the risk of deportation all contributed to the development of this psychopathology of crossing, or unique effects of migration stressors, for Haitian asylum seekers in Canada (Cenat et al., 2020).

Migrated individuals often experience a high prevalence of mental health problems and traumatic experiences, including personal/interpersonal, political, and labor-related (Knipscheer et al., 2009; Levers & Hyatt-Burkhart, 2012). The process of migration can be a long, dangerous, and arduous process, sometimes involving trekking many miles on foot. One such example includes Ethiopians leaving their home country for Saudi Arabia in the hopes of leaving poverty and political violence behind. Another example includes the “Lost Boys of Sudan,” some 20,000 children forced to flee the civil war in 1987, making the dangerous 1,000-mile trek, on foot, to Ethiopia (International Rescue Committee, 2014). The road to be taken, with hopes for a better life, often is perilous and may include violence and exposure to the elements. It is not surprising, then, that migration-related stress is a strong predictor of depression (Fanfan et al., 2020). Pre-migration stress also influences this relationship, as it was shown in a Haitian sample of migrants that being present in Haiti during the 2010 earthquake had an amplifying effect on the relationship between migration-related stress and depression for Haitian immigrants in the United States (Fanfan et al., 2020). Even when migrants survive the journey, trials do not necessarily cease when the destination is reached.

The receiving community, into which migrants relocate, has an important influence on migrant mental health. Specifically, experiencing discrimination is directly associated with worsening mental health as evidenced by an increase in depression, anxiety, and posttraumatic stress symptoms (Lincoln et al., 2021). Indeed, the post-migration environment is a key factor related to well-being, correlating with quality of life for migrants (Zou et al., 2021). Not only do migrants have their individual experiences of the migration to process and integrate, but they also have to experience a new culture and its people, with concomitant issues that are likely to be different than those of their homeland and those to which they are accustomed.

accustomed.

Acculturation is the dynamic process of being exposed to a new culture and integrating into the culture, to varying degrees; however, acculturation is not without its challenges and subsequent stress (APA, 2012). Many migrants retain a cultural identity from their homeland, but this identity may clash with their new cultural surroundings. Aside from potentially not knowing the language, tensions between a collectivist and an individualistic cultural ethos can be felt. Additionally, children may feel as though their parents are ill-equipped to advise them in this new culture, and the children often assume a caregiver role of helping their parents with filing taxes, for example, as a sort of cultural ambassador—using skills that they may have picked up at school or had to learn on their own for survival. It was found that migrant adolescents, compared to host adolescents, had significantly more behavioral problems, but that these problems tended to taper off after about 2 years (Fang et al., 2020).

Confluences of Crises Leading to and Intersecting With Migration

Migration can be a voluntary act, such as when people migrate willingly for work; however, oftentimes people are compelled to relocate due to strong forces largely outside of their control. Fleeing religious persecution, civil unrest, war, degradation of the environment and subsequent resource scarcity, and climate change are among some of the reasons an individual or group of individuals may be forced to leave their homes of origin. Financial insecurity, at all points along the journey, also creates stress (Cenat et al., 2020). One of these circumstances alone may present substantial difficulties, but their intersections with traumatic experiences can compound into a complex crisis. For example, a World Bank report (Ratha et al., 2020) explores the intersection of the multiple crises associated with migration and COVID-19. The report states that “[t]he economic crisis induced by COVID-19 could be long, deep, and pervasive when viewed through a migration lens. Lockdowns, travel bans, and social distancing have brought global economic activities to a near standstill” (Ratha et al., 2020, p. viii).

Anthropogenic climate change causes drastic alterations in the environment and limits the resources that are available to people, which then can lead to tension and violence over those restricted resources. Thus, people may be led to environmentally motivated migration and termed “climatic refugees” (Cianconi et al., 2020, p. 11) or ecological migrants, illustrating how one crisis situation can lead to another (Fang et al., 2020). In the case of ecological migration, people are uprooted from their homes and the familiarity of life as they know it. In the next section, we focus on the complex crises and trauma that arise from anthropogenic climate change, or climate change spurred by the actions—or inactions—of humans.

COMPLEX CRISES AND ANTHROPOGENIC CLIMATE CHANGE

Anthropogenic climate change influences nearly every aspect of life on this planet, and it serves as a common link that is transforming our environment in radical ways, from dwindling glaciers and icecaps in the most remote parts of the world to rising water levels and “sinking cities,” like New Orleans. Because the change is seemingly gradual, the effects may be easy for some to ignore or deny, at least currently, depending on their individual circumstances and geographical location, but these effects of climate change are pervasive and unlikely to stop or reverse without concerted attention and action.

Mann (2012, 2021) asserts the scientific fact of anthropogenic climate change, especially as underscored by the unprecedented number of weather events, including heat, heat waves, droughts, wildfires, super storms, and floods. The price tag for anthropogenic climate change is enormous; however, while the shift toward sustainable energy may be costly, the cost of *not* taking action will be far greater (Mann, 2021; U.S. Global Change Research Program, 2020). Dire consequences for human life already have become apparent for some, although they sometimes are disguised by or subsumed within other natural disasters or crises. In this section we provide a brief overview of climate change, as it relates to the topic of complex crises, and we examine the psychological effects of climate change and how it intersects with other crises.

Anthropogenic Climate Change

Life as we know it is made possible by the environment, which, by default, includes the climate, or vast array of meteorological elements such as temperature, atmospheric pressure, and rainfall, among others. According to NASA, climate change refers to long-term changes in the Earth's weather patterns that have widespread effects; such shifts are produced by natural warming as well as by human behavior (NASA, n.d). Empirical evidence overwhelmingly supports that human behavior has led to drastic changes in the Earth's weather patterns by means of carbon dioxide increases due to fossil fuel emissions, especially since the industrial era (Intergovernmental Panel on Climate Change [IPCC], 2014; Mann, 2012, 2021; Melillo et al., 2014; NASA, n.d.), hence the term "anthropogenic," or man-made, climate change. What is particularly frightening is that the current level of exploitation of the planet's natural resources may not produce effects that are felt immediately, but that are compounded over time (Levers & Drozda, 2018; Liu et al., 2007).

From an ecological perspective, "the reciprocal and transactional nature of the individual's effect on the environment, and vice versa, should not be minimized" (Levers & Drozda, 2018, p. 89). Levers and Drozda (2018) analyzed the existing social science literature related to anthropogenic climate change, and they emphasized the importance of a social science perspective in considering the perils of climate change. A major reason for emphasizing this is to develop a robust social science perspective, because if there is going to be any abatement of climate change effects, of necessity, it needs to involve human beings, and thus, it will require better understandings of human attitudes and human decision-making. In this way, humans are not separate from their environment; however, their actions influence the environment, and subsequently, changes in the environment influence humans. When we refer to climate change throughout this section, we are referring to the effects of the exacerbation of climate change by human behavior (anthropogenic climate change), while also acknowledging that there are natural warming trends, but that the rate at which change is occurring presently is greatly influenced by human behavior.

Climate change does not affect everyone equally, with economically disadvantaged people bearing the brunt of the stress (Parry et al., 2019; Stocker et al., 2013; UN, Climate Change, 2014). The deleterious effects of climate change are far-reaching, permeating beyond mere temperature shifts, to threaten agriculture, economy, ecosystems, way of life, individual physical and psychological well-being, and the very existence of some populations with limited access to resources (Bavel et al., 2020; Levers & Drozda, 2018). Water, for example, is a necessity for life to flourish. Botswana is among the countries most affected by water stress due to climate change (Boikanyo & Levers, 2017), which makes the situation for poor people in this country especially urgent. Water rationing may be a foreign concept to most people in the developed areas of the world, but it is an all too real experience for some individuals in arid countries like Botswana (Boikanyo & Levers, 2017). Rivers and dams have dried up, which may force people to make changes for which they do not have the resources. Whether people choose to stay or leave their home, the effects that climate change can have on an individual's mental health are troubling (APA, 2017).

Psychological Effects of Climate Change

A review of relevant literature in the behavioral and social sciences underscores the negative effects of climate change on human well-being and warns of the exacerbation of such consequences if human behavior continues along the same indiscriminate and destructive path (Levers & Drozda, 2018). Empirical evidence supports that environmental stressors produced by climate change threaten the psychological well-being of individuals through direct and indirect pathways, including the mental health of children and adolescents, jeopardizing their prospects for good physical health and a bright future (Bavel et al., 2020; Cianconi et al., 2020; Clemens et al., 2020; Hanna & Oliva, 2016; Howard et al., 2020; Kabir, 2018; Larr & Neidell, 2016; Obradovich et al., 2018). The threat to psychological well-being can include increased risk for psychological stress, depression, anxiety, addiction,

can include increased risk for psychological stress, depression, anxiety, addiction, posttraumatic stress, exacerbation of previous trauma, and even suicide (Howard et al., 2020; Kabir, 2018). For example, individuals from the hill-tracts region of Bangladesh indicated that alterations in the climate and their environment affected their ability to work, which in turn produced feelings of decreased self-worth (Kabir, 2018). When combined with other stressors and previous traumas, it was reported that the potential for suicidal ideation appeared to increase (Kabir, 2018). This particular linkage between climate change and detrimental psychological effects was observed anecdotally by health workers, though a direct causal relationship between climate change and suicidal ideation was not determined (Kabir, 2018).

For many, work is closely tied with survival, identity, fulfillment, and accomplishment—without it, despair may befall people. Similarly, a large-scale study of data from the United States found that people's mental health worsened with hotter temperatures, increased precipitation, and multiyear warming (APA, 2017; Obradovich et al., 2018). Researchers also found that exposure to tropical cyclones increased mental health issues (Obradovich et al., 2018). Researchers have reported that farmers and ranchers in the United States are feeling the effects of climate change via anxiety and distress (Howard et al., 2020). Because climate change has come with an increased incidence of extreme weather, the everyday lives of people are affected (Cianconi et al., 2020). This may be due to storms, droughts, flooding, decreased access to drinking water, heat waves, decreased air quality, fires, and the reemergence of diseases—all of which can influence psychological well-being (Cianconi et al., 2020).

The impact of climate change on mental health has become so evident that new terms have been generated to help describe it. These terms include “ecoanxiety,” “ecoguilt,” “ecological grief,” and “solastalgia” (Cianconi et al., 2020). Issues related to climate change are complex, particularly because not everyone is affected equally nor at the same time, thereby not only making the effects difficult to measure, but also rendering the health risks to disadvantaged populations less visible to policy makers and researchers (Cianconi et al., 2020; Parry et al., 2019). For instance, people who are directly in contact with the land and deal with its resources recognize instantly how climate shifts are changing life, but people who are not an integral part of harvesting food, for example, may not feel the weight directly associated with shifts in the climate. When temperatures rise and resources that are needed for survival become scarce, it is not surprising that climate change directly and indirectly leads to a whole host of other issues.

Intersection of Climate Change With Other Crises

The environments in which people live can be taken for granted in terms of their stability. Climate change disrupts homeostasis for individuals and groups, threatening ways of life, safety, and survival. Disruption is a critical factor in understanding the impact of climate change in disaster scenarios and on communities and individuals; this, in turn, makes adaptation and resilience building crucial mechanisms for responding to climate-related disruption (Rodin, 2014). In this section we discuss how climate change is related to myriad changes in human behavior and the environment and how it contributes to complex crises.

Changes in the weather influence people's daily activities and also influence when crime is committed (Linning et al., 2017). Warmer temperatures are generally associated with increased human aggression as well as higher incidence of criminal behavior (Boikanyo & Levers, 2017; Brunsdon et al., 2009; Linning et al., 2017; Ranson, 2014). Data from the United States indicate that this increase pertains to all criminal behavior, such as theft and violence, and even rape and murder (Ranson, 2014). Simple seasonal change can affect crime rates, though researchers suggest that it may be useful to differentiate between types of crime (Linning et al., 2017). One can imagine, then, how more extreme and long-lasting changes can influence human behavior.

The factors leading to war and civil unrest are interconnected and complex, but regular and exacerbated climate change may amplify the effect of existing problems, make conflict more likely to occur, or serve as a catalyst for plans already set in place (Diaz & Trouet, 2014; Hicks & Maldonado, 2019; Mach et al., 2019). For example, those living in poverty are often

less likely to have the resources necessary to adapt to climate change when compared to those in higher socioeconomic status brackets. When resources are scarce due to climate change, this may lead people to do things that they normally would not do for survival, or, as explicated in the previous section, they may choose or be forced to leave their homeland. While there certainly are nuances in the complex relationship between anthropogenic climate change and war and civil unrest, evidence suggests that even the more expected climate fluctuations and patterns, such as with the *El Nino—Southern Oscillation*, are strongly associated with conflict and civil unrest (Hicks & Maldonado, 2019), and that climate variability and change are linked to increased risk of armed conflict within countries (Mach et al., 2019). Not only is human behavior influenced by climate change, but physical health is as well.

Climate change effects are ubiquitous, influencing human physical health. One such example includes exacerbation of infectious disease conditions via air pollution (Patz et al., 2014). Furthermore, the fossil fuel emissions that lead to climate change are responsible for forming ozone and particulate matter in the air (Larr & Neidell, 2016). Such pollution can affect the heart and lungs of children, for example, and can lead to respiratory symptoms and aggravate asthma (Larr & Neidell, 2016). Serious pollution leads to and worsens health problems. Climate change also is one of the factors that can lead to more wide-scale health problems, including pandemics. According to Dr. Aaron Bernstein, the director of Harvard Chan C-CHANGE, treating climate change and global health policy as separate issues has been a gross oversight, citing the current biodiversity crisis, or mass extinction (Coronavirus and Climate Change, n.d). Many of the primary causes of climate change simultaneously increase the risk for pandemics; this can include deforestation, which forces animals to migrate to places that they otherwise may not have been, thus coming into contact with other animals and humans with whom they normally would not come into contact (Coronavirus and Climate Change, n.d). Thus, this complex forced migration increases the spread of germs and subsequently contributes directly and indirectly to mass loss of life.

COMPLEX CRISES AND MASS CASUALTIES

The interconnected issues of complex crises and mass violence are detailed in Chapter 20, "Mass Violence." However, the focus in the current chapter relates to mass casualties, in general, with discussion about two specific situations involving mass casualties, that of anthropogenic climate change and that of the most recent COVID-19 pandemic. Aspects of anthropogenic climate change may lead to situations of mass casualties. For example, an array of complex and interconnected issues has evolved into a wide-scale pandemic that continues to ravage life around the world. In this section, we discuss mass casualties that have resulted from anthropogenic climate change and those that have resulted from the COVID-19 pandemic.

Mass Casualties and Anthropogenic Climate Change

Climate change is listed among the top international threats (Poushter & Huang, 2019). Some fluctuations in the Earth's temperature and weather patterns, including warming, occur without human interference; however, as previously elucidated, human behavior has been instrumental to the exacerbation of some of these more extreme effects on our climate, having unprecedented consequences that threaten human life. For example, the heat wave of 2018 in Japan caused over one thousand people to lose their lives (Imada et al., 2019). Attribution science, or the branch of science that allows for investigating the influence of climate change on individual weather events, established that this heat wave could not have occurred without human-induced global warming, or anthropogenic climate change (Imada et al., 2019). Similarly, the Australian bush fires continue to endanger people and ecosystems, and attribution to anthropogenic climate change has been verified (van Oldenborgh et al., 2020). Climate change in general seems to remain an elusive concept, skirting accountability for loss of life, often overshadowed by the other crises that it leaves in its wake. However, direct examples of mass casualties linked to anthropogenic climate change exist, as in Japan

direct examples of mass casualties linked to anthropogenic climate change exist, as in Japan and Australia, and this link no longer can be ignored or denied.

Mass Casualties and the COVID-19 Pandemic

An invisible killer has struck our planet. The novel coronavirus, SARS-CoV-2, or COVID-19, decimated the world population throughout 2020, with such a fury as modern times have never seen. In the first 3 months alone, nearly one million people were infected with the virus and 50,000 succumbed ([National Institute of Allergy and Infectious Diseases, 2021](#)). At the time of this writing in early 2021, over 2.24 million people have lost their lives to this relentless virus ([Coronavirus World Map, 2021](#)), although the reported numbers may actually underestimate the true loss of life. The weight of the loss is catastrophic, and the damage to the mental health of survivors is equally devastating.

Psychological Toll of COVID-19

Life has been forever altered as a result of this pandemic, dealing out many blows to the individual psyche. The collective stress and weight of the sheer numbers of those who have lost their lives to the virus is daunting, along with the shrinking of coping strategies available to people due to stay-at-home orders. According to PEW Research, four in ten American adults say they know someone who has been diagnosed with COVID-19, with African Americans being more likely to know someone who has been hospitalized or died from the virus ([Kramer, 2020](#)). In fact, data are already available that highlight the disproportionately higher COVID-19 cases and deaths in U.S. counties that have higher proportions of African American and Hispanic populations ([Khanijahani, 2020](#)). Recent data show that U.S. counties with a higher proportion of the population residing in racially or socioeconomically segregated census tracts had disproportionately higher COVID-19 deaths; the data further indicate that a reciprocal increase in the percentage of county residents living in racially and socioeconomically segregated areas has been associated with a much greater increase in COVID-19 deaths ([Khanijahani & Tomassoni, 2021](#)). Such health disparities naturally lead to behavioral health inequities as well. Compounded trauma and grief due to this pandemic include loss of jobs, loss of ways of life prior to the pandemic, isolation, and, of course, the loss of loved ones, friends, and family members. The health disparities that are intertwined throughout all of these important psychological issues also have forced us to acknowledge the degree to which social justice, or lack thereof, is a paramount factor of the pandemic.

Exacerbation of Stress

The toll of pandemic stress is vast and varied, including understandable fear and worry, changes in sleep or eating patterns, difficulty sleeping or concentrating, chronic health problems being aggravated, mental health declining, and increased substance use according to the [Centers for Disease Control and Prevention \(2020\)](#). Everyone responds differently to crises, and some people may respond more strongly to the circumstances brought about by COVID-19. These individuals can include but are not limited to children and teens, those with underlying medical conditions,

healthcare workers, those in the food industry, people who are socially isolated or have mental health conditions, homeless individuals, and racial and ethnic minorities (CDC, 2020). When the present is uncertain and scary, and the future feels even less clear, it can be hard to cope with the massive loss of life on a global scale as well as an individual scale, not to mention livelihoods being destroyed. Young people and those financially affected by the pandemic are experiencing increased levels of psychological distress (Keeter, 2020). Because isolation is a risk factor for suicide, there is growing concern about rising suicide rates among teens and other young people. Many do not have the means to cope effectively.

Poverty and Lack of Resources

Poverty affects all aspects of life. When it comes to COVID-19, those in poverty may not have the opportunity to distance socially if they are living in an overcrowded space or in a studio apartment with another person. Needing to take public transportation to work can put people at increased risk, their jobs could be precariously hanging in the balance, or maybe they have lost jobs. Six months after the pandemic started, half of the people who reported job loss were still unemployed (Parker et al., 2020). Furthermore, the virus is expected to put an estimated 150 million people into extreme poverty in 2021, with the World Bank asserting that “the convergence of the COVID-19 pandemic with the pressures of conflict and climate change will put the goal of ending poverty by 2030 beyond reach without swift, significant and substantial policy action” (2020, “Eight Out of 10 ‘New Poor’ Will Be in Middle-Income Countries,” para. 5). Understandably, tensions arise if people are operating within a system in which they do not agree with the decisions being made, such as being forced to close their businesses. Dire circumstances, poverty, and the lack of adequate resources push people toward conflict when their survival is on the line.

COMPLEX CRISES AND WAR AND CONFLICT

The interconnected issues of war and trauma are detailed in Chapters 23 and 25. However, the focus on war and its effects, in the current chapter, reflects the complex intersection of war and conflict situations with other forces, which can result in a set of complex crises. In this section, we briefly examine the effects of war, primarily the psychological toll, as well as the effects of civil unrest.

Effects of War

War harms on multiple levels; it harms us physically, psychologically, emotionally, socially, existentially, and spiritually. Regardless of how a person is involved in and affected by the violence that war entails, the instability, uncertainty, and fear associated with wartime permeates all parties involved. War exposure and armed conflict can increase mental health issues such as PTSD as well as overall psychological distress (Haer et al., 2021). Furthermore, depending on the particulars of the situation, war can influence social capital, or the structure and norms that hold a society together and connect people to one another (Haer et al., 2021). This has the potential, in drastic ways, to uproot the familiarity that is associated with people’s daily lives, culture, and routines. Furthermore, psychological distress and PTSD are negatively associated with social capital—particularly involving interactions with other people and relying on others (Haer et al., 2021), highlighting the interconnectedness of these individual and societal issues.

It seems to be within our imagination to sense how wars can cause food and water scarcity, but it seems a bit more difficult for people to grasp how food and water insecurity can ignite war or civil unrest. Worsening climate change seems to be increasing the risk for violent conflict within countries (Mach et al., 2019). Bhatt (n.d., para. 2) reports, “Alarming, several studies suggest that climate change makes conflicts such as civil war or genocide more likely.” Obviously, this complex issue includes an intricate set of interrelated and intersecting forces. It is not climate change alone that causes war or civil unrest; Bhatt (para. 2) refers to climate change as a “threat multiplier.” It is the interaction of climate change with multiple

climate change as a “threat multiplier.” It is the interaction of climate change with multiple risk factors like poverty, political upheavals, and crime that then amplifies the effects of climate change (Boikanyo & Levers, 2017; Levers & Drozda, 2018). Syria is a case in point, in which the adverse environmental effects of climate change sparked migration and eventually civil war (Bhatt, n.d.; Friedman, 2015). One of the earliest civil wars attributed to climate-induced origins was in Sudan, as documented in a thorough assessment by the United Nations Environment Programme (UNEP, 2007).

Effects of Civil Unrest

When people are in danger, are oppressed, or feel unheard or unprotected by a government charged with protecting them or acting in their best interest, people may organize in order to demonstrate their views, gain attention, and garner support. Tensions burn hot when there is disagreement over how people are treated, how tax money is spent, and how justice is served by police, legislators, and other authority figures. Precisely because of mounting tensions, acts of mass civil disobedience potentially, and sometimes easily, can turn into civil unrest and give way to mass violence. Examples of civil unrest can be seen internationally, nationally, regionally, and locally. In recent times alone, we have witnessed high levels of civil unrest, seemingly everywhere; some of these events are primarily politically motivated, but others involve complex crises that intersect with many of the issues under discussion here, like climate change.

When hostilities, justified or not, spill over into violence, public safety may be threatened and compromised; people may be harmed or even killed, and individuals may be traumatized. Mental health professionals are likely to become involved in multiple ways and at a number of levels. We may be asked for assistance with crisis intervention, with attending to the post-event psychosocial effects of trauma, and even with peace-building efforts to prevent further violence. Recent calls for police reform, for example, may bring a new wave of mental health professionals being called to respond to crisis situations and to address the psychosocial problems of people without adequate resources to fend for themselves. In other words, it is not an impossibility that mental health professionals may end up responding to situations to which police officers historically have been called, but which actually require mental health interventions. Counselors and other professional helpers need to possess the crisis intervention and trauma counseling skills that are being promoted throughout this textbook, in order to respond professionally and competently.

RELEVANCE OF INTERSECTING TRAUMA AND COMPLEX CRISES

It is critical that all mental health clinicians, public health clinicians, health policy implementers, and community planners begin to recognize how trauma and crises do not exist within a vacuum. Not only is an ecological perspective helpful, it is imperative, in order to understand the intersections of trauma and crises that form complex crises, as they continue to unfold in our world. We use this notion of intersection or convergence or confluence as a way of framing and understanding the exponential interconnectedness of trauma and multiple crises that often is overlooked. In this way, widening our field of vision helps us not to err by assuming that a crisis is occurring in isolation, when there clearly is a synergy with trauma and additional crises happening simultaneously. Rather, this allows us to enter into dialogues about creative and holistic solutions that can take into account multiple contributing factors within both local and global contexts, as needed. With the spirit of intersection in mind, as we discuss complex crises, we submit that the nature of each individual crisis not only overlaps and interacts with people’s individual and social identities, but also overlaps and interacts with the nature of other crisis situations to form a complex crisis. In this section, we discuss complex crises in reference to recent neuroscience findings and to aspects of relevant mental health diagnoses.

Complex Crises and Neuroscience

The interconnected issues of recent neuroscience research findings and how the brain

The interconnected issues of recent neuroscience research findings and how the brain processes trauma are detailed in Chapters 2 and 4. However, the focus on brain science and the intricate interactions between the brain and trauma, in the current chapter, reflects the complex intersection of the other forces being discussed here with brain function, and how brain activity may contribute to a set of complex crises. Probably the most salient brain activity to consider, within the context of this discussion, is fear. When we perceive the threat of danger, during any crisis situation or trauma event, our autonomic nervous system engages; the parasympathetic nervous system may respond to fear by moving into freeze, or the sympathetic nervous system may respond to fear by moving into fight or flight. As discussed in greater detail in Chapters 2 and 4, Polyvagal Theory recently has informed our understandings about the implications of the vagus nerve during this engagement, and how the brain communicates with other organs in the body toward mobilization, social engagement, and immobilization (Porges, 2001, 2011).

Trauma directly affects the brain of both children and adults (Cassiers et al., 2018). Although specific traumas may influence an individual's system differently, chronic exposure to threatening conditions can have longstanding effects. The fight-or-flight reaction may be familiar, and when it comes to complex crisis, individuals' nervous systems may remain on overdrive for prolonged periods of time. However, recent and emerging research suggests an even more expansive explanation of how trauma can manifest in neurobiological changes in the body and resulting behavior, including social interactions and system shutdowns.

Interactions between people and the environment directly affect brain functioning, and subsequently which higher-order thinking processes and behaviors are available at any given time. Porges' (2011) Polyvagal Theory posits that the vagus nerve is a critical part of communication throughout the body and among the various organs, and so determines this level of functioning. The vagus nerve interacts with the autonomic nervous system (ANS), the system that controls bodily functions that are largely unconscious (we do not normally think about our breathing or heart beats while engaged in routine activities). At an unconscious level, bodily functions seem to be assessing: Is it OK to "rest and digest" (parasympathetic part of the ANS), or do I need to be on alert and prepare to react quickly (sympathetic part of the ANS)? It is the sympathetic nervous system that mobilizes us to fight or take flight when we perceive danger. Different parts of the vagus nerve serve different mechanisms. The dorsal branch controls the fight-or-flight and shut-down responses. These responses may involve muscle fatigue, dissociation, and changes to heart and lung functioning (Wagner, 2016). The ventral branch controls the social engagement system occurring above the diaphragm (Wagner, 2016).

There are three basic levels of functioning, according to Polyvagal Theory: being at ease, the fight-or-flight response, and partial or complete system shutdown. When we feel safe, we are able to engage socially with others, and myriad expressions are available to us (Porges, 2001, 2011, 2018). In this state, it is possible for us to communicate with other people in a reciprocal, comforting, and nourishing way. However, when we experience a trauma, our very chemical makeup is affected, and our ability to accurately interpret our surroundings may be impaired—we are more likely to see other people as threatening (Porges, 2018). Physical changes occur that alter access to higher levels of functioning, like perceptions and decision-making. When we are in danger or perceive the threat of danger, our access to clear, logical thinking is limited or shut off. We may be in a fight-or-flight state, and are thereby quick to react, or conversely, an involuntary nervous system response to shut down may be activated. Down to a neurobiological level, our bodies are screaming "danger!", even if the threat has long since passed. This "stuckness" is a hallmark of trauma and is integrally related to vagus nerve activity. The differences in functioning levels are the cornerstone of Polyvagal Theory. People who have experienced trauma in their lives often find it hard to feel safe and are likely operating at a level of functioning that inhibits them in some way, in terms of fight or flight or shutdown. The more primitive brain (brainstem structures) functions remain available when danger presents itself, with social systems playing less of a role and prosocial behaviors inactivated (Porges, 2001). Thus, Polyvagal Theory is instrumental in understanding mass trauma and complex crises: There is a biological basis for social behavior, whether prosocial or antisocial (Box 24.2), which necessitates holistic pathways to heal from trauma (Porges,

or antisocial (BOX 24.2), which necessitates holistic pathways to heal from trauma (Porges, 2001).

BOX 24.2

Case Illustration

To illustrate the integral effects of trauma on daily life, we might consider, for example, a person who has been living from paycheck to paycheck. This individual has been on high alert most of the time and in fear of losing their job because they are a single parent. The COVID-19 pandemic has hit, and they first have their hours cut at work, having to choose what bills get paid and forgoing many meals. The person then has learned that their employer needs to close the business, thus eliminating the person's job. With their brain in survival mode, they are not as communicative or close with their child anymore and are finding it increasingly hard to make daily decisions. More panicked by the family's escalating economic problems, the person becomes overwhelmed, even by seemingly simple tasks. Remember, crises for individuals can be complex and do not have to surround just isolated events—a person can be functioning in "crisis mode" for years, and the deleterious effects on the body become apparent.

Reflection Questions:

- How do we begin to frame the stress and anxiety levels presented by this client?
- How might we begin to frame immediate and shorter-term interventions?
- Are there any referrals that we might consider?
- How might we begin to frame the need for longer-term interventions?

To illustrate how trauma permeates multiple bodily systems, Kolacz et al. (2019) point out that gastrointestinal (GI) disorders and psychiatric disorders, including PTSD, frequently co-occur. In a synthesis of relevant studies, researchers highlight the neurobiological interconnection between GI functioning and socioemotional problems, triggered by acute and chronic threat states that influence the autonomic nervous system (Kolacz et al., 2019). Responses to threat alter sensory-motor processes and the feedback loops that keep the body in homeostasis (Kolacz et al., 2019). It may not be surprising that experiencing trauma can affect many areas of life.

Complex Crises and Relevant Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Highlights

Although the current **Diagnostic and Statistical Manual of Mental Disorders** (5th ed.; *DSM-5*; American Psychiatric Association, 2013) does not include eco-anxiety, climate anxiety, or other related terms, an official diagnosis that describes these timely states or conditions may not be far off. The American Psychological Association acknowledges the effects of climate change on the psyche (Clayton et al., 2017). Recent research has begun to highlight how climate change can exacerbate existing mental health symptoms as well as increases in "trauma and shock, post-traumatic stress disorder (PTSD), compounded stress, anxiety, substance abuse, and depression" (Clayton et al., 2017, p. 7). Among the diagnostic categories that necessarily are considered when working with a client who is experiencing, or has experienced, a situation of complex crises, perhaps some of the most important to appraise are PTSD, anxiety, depression, dissociation, and suicidality. It is beyond the scope of this chapter to provide detailed descriptions of these diagnostic categories; rather, the emphasis here is that the astute clinician needs to explore potential diagnoses within the context and parameters of the presenting set of complex crises, while also recognizing that anxiety and depression can appear as symptoms of underlying trauma.

COMPLEX CRISES AND SOCIAL JUSTICE

When community trauma strikes, movement away from ethnocentric monoculturalism and

When community trauma strikes, movement away from ethnocentric monoculturalism and toward multicultural pluralism is needed even more than during usual circumstances. This shift entails the ability to see beyond our own worldview and acknowledge the worldviews and experiences of other people as valid. Epistemologically, multicultural pluralism means acknowledging that there is more than one way to behave in this world and more than one way to conceptualize culture. Shedding ethnocentric monoculturalism means shedding the blinders that narrow an individual's view to the point that they see only their own worldview as right and acceptable.

Social justice, or the idea that everyone should have equitable opportunities, protections, access to resources, and rights in society, is integrally related to experiences and discussions about mass trauma, which is discussed in greater detail in Chapter 20 of this textbook. Unprocessed intergenerational trauma is transmitted across time and space by way of implicit and explicit messages about certain groups of people, which influences oppression and marginalization of such groups (Charles, 2019), and we certainly continue to learn about the epigenetic transmission of the profound effects of intergenerational trauma. Because some beliefs, even unconscious beliefs and bias, are so deeply rooted, people may feel defensive and as though their very identities are being threatened when questioned or invited to enter into a dialogue. Poverty and lack of adequate resources, among various populations around the world, remain problematic and contribute to the multiplier factor of complex crises. Just as an example, one consequence of Western development that we rarely discuss is the economic disparity that has been created among people of color and in the geographic hemispheric south. We briefly discuss these important social justice issues in this section.

Multicultural Pluralism

In order for a society to exhibit multicultural pluralism, it must allow for the retention and expression of unique cultural and ethnic identities and perspectives. In the case of mass trauma, such inclusion of myriad voices and perspectives may look like the amelioration of different conceptualizations, interpretations, and healing processes from the traumatic event, series of events, or historical compounded trauma. Counselors are in an especially unique position to be able to encourage this retention and expression throughout the healing process. To aid counselors in this process, the term "multicultural pluralism" can be broken down. The word "pluralism" connotes a broader philosophical idea that multiple truths exist (Pedersen et al., 2018). When pluralism is coupled with multiculturalism, specific and often marginalized identity groups (e.g., cultural, religious, and racial identities) are embedded within the concept of multiple truths—highlighting how truth may be conceptualized differently within and between groups. Regardless of where a counselor practices, counseling from an affirming multicultural pluralistic framework is needed with the added recognition that the experience of mass trauma may be rooted deeply in many cultural and racial groups. It is critically important to acknowledge that multiple truths necessitate multiple paths to healing, and decolonizing this process begins with the embrace of multicultural pluralism.

Cultural Competence, Cultural Humility, and Beyond

Cultural competence and cultural humility have gained much attention, as the counseling profession strives to provide relevant and accessible services to diverse clients, but the two terms have sparked some debate and controversy over which may be more important. Both cultural competency and cultural humility invite the self-reflection of helping professionals, but some view cultural competency as unattainable, because becoming completely competent in cultures other than one's own typically is not possible (Greene-Moton & Minkler, 2020). Cultural humility specifically highlights the power imbalances, which need to be addressed and equalized, between groups of people (Greene-Moton & Minkler, 2020; Tervalon & Murray-García, 1998). Some may view the two terms to be in competition with one another, but the overlap between the two constructs is as apparent as the utility of both. Combining the terms has been suggested as a way to synergize the two constructs (Campinha-Bacote, 2019), thus promoting a paradigm shift that warrants the combined benefits of both cultural competence and cultural humility, so that these two important constructs are no longer

competence and cultural humility, so that these two important constructs are no longer viewed as fragmented and in opposition with one another.

Another recent driver in the discourse surrounding multicultural counseling is the imperative to decolonize counseling and psychological practices (e.g., [Conwill, 2015](#); [Gelberg & Poteet, 2018](#); [Goodman, 2015](#); [Shin, 2015](#); [Smith & Chambers, 2015](#)). [Gelberg and Poteet \(2018\)](#) identify issues of decolonization as “related to the harm that Euro-American contemporary psychology, research, social work, education, and counseling can impose on individuals who do not endorse the values of the dominant culture” (2018, p. 1). They further assert that “mental health professionals should be trained to recognize elements of their professional work that are based on biases that still reflect Euro-American colonization” ([Gelberg & Poteet, 2018](#), p. 1). Such shifts in conceptualization allow for the interpretation that everyone is ever evolving, while underscoring the need to remain culturally aware (of self and others), in order to challenge systems and institutions that maintain and perpetuate the status quo of injustice. An example of this, in the context of complex crises, may encompass recognizing the injustices associated with poverty ([Smith & Chambers, 2015](#)) and then discerning the intersections of how people living in poverty are more likely to experience the negative consequences of climate change, and how this then can lead to complex crises and trauma ([Intergovernmental Panel on Climate Change, 2014](#)). In a very real sense, the intersections that we discuss throughout this chapter, as they pertain to complex crises, also embody *intersectionality*, as the term typically is used in the diversity literature (e.g., [Crenshaw, 2008](#)). Awareness of such dynamics, along with focused efforts in response, can assist counselors in bringing about a more equitable distribution of resources, power, opportunity, and access to education and healthcare.

COUNSELING IMPLICATIONS OF COMPLEX CRISES

Regardless of where in the world counselors practice, they are likely to encounter individuals who personally have been through some of the crises described in this chapter, or perhaps have family members who currently are experiencing or have experienced a large-scale crisis. Complex crises counseling places extreme and unique burdens on counselors, particularly if they are providing services while the trauma is ongoing. When working in an international context, an unstable political environment can even lead to aid workers being victims of theft, physically attacked, kidnapped, or even killed ([Stoddard et al., 2014](#)). And of course, as we saw in the U.S. National Capitol on January 6, 2021, first responders and police were killed and hurt by an unruly mob. In this section, we discuss some of the unique challenges for counselors working with complex crises, the importance of adaptation and sustainability, and the need for building resilience and using other community-based trauma-informed strategies.

Challenges of Working With Complex Crises

In a CDC publication, [Nilles et al. \(2020\)](#) describe unique challenges for humanitarian aid workers, highlighting safety and security concerns as well as mental health issues. Among the critical safety and security concerns identified for humanitarian aid workers are (a) exposure to the disaster or conflict environment that precipitated or sustained the crisis; (b) damaged or absent infrastructure, including sanitation facilities and living accommodations; and (c) high levels of insecurity ([Nilles et al., 2020](#), “Unique Challenges for Humanitarian Aid Workers,” para. 2). Among the important mental health issues identified for humanitarian aid workers are (a) stressful environments and (b) working long hours under adverse or extreme conditions ([Nilles et al., 2020](#), “Unique Challenges for Humanitarian Aid Workers,” para. 3). Similarly, the Substance Abuse and Mental Health Services Administration ([SAMHSA, 2020](#)) advises mental health approaches that align with the unique needs of populations experiencing various crises and the professionals who deliver those crisis services. Furthermore, unique ethical issues may arise when counselors find themselves functioning in a multicultural context, having to negotiate boundaries in new ways, interfacing with alternative healing modalities, and confronting ethical dilemmas not readily defined in

current ethical standards (Tarvydas et al., 2017, 2018; Teahen et al., 2017). Notably, many of the current ethical standards referenced in the counseling profession may stem from a more Westernized notion of what helping professionals do and how they function within communities, thus illuminating the need for decolonization efforts, as previously discussed.

Another challenge involves the historical purview of all that involves a behavioral health perspective. Traditionally, mental health interventions have been equated with a focus on psychological concerns. But as soon as we adopt an ecological perspective of the individual's interface with society across all social systems, we begin to entertain a broader frame of reference regarding behavioral healthcare. For example, many health professionals are calling for the inclusion of a mental health point of view within the emerging discourse about anthropogenic climate change, as well as for health vulnerability assessments, in order to expand the conceptualization of health and wellness beyond the physiological (APA, 2017; Hayes & Poland, 2018). This of course relates to other health disparities in low-resource communities and the need for advocacy efforts concerning behavioral healthcare, especially within the context of complex crises. In fact, the trauma derived thereof is a collective experience, and helping individuals with trauma also aids in increasing social capital and healing societies at large (Haer et al., 2021).

Relative to complex crises, Porges' relatively recent Polyvagal Theory offers insights that are relevant to the interconnectedness of behavioral health and physiological health perspectives. Porges even has proposed a "fourth paradigm":

Thus, it may be possible that creating states of calmness and exercising the neural regulation of brainstem structures may potentiate positive social behavior by stimulating and exercising the neural regulation of the social engagement system. This perspective or intervention paradigm, which focuses on biologically based behaviors, might be viewed as a fourth paradigm or approach to modify behavior in contrast to behavioral (i.e., learning theory-based), biochemical (i.e., pharmacological), and psychotherapeutic (i.e., including psychoanalysis and cognitive therapies) intervention strategies. (Porges, 2001, p. 142)

Adaptation and Sustainability

Planet Earth and all of her inhabitants are in crisis, in terms of anthropogenic climate change; human populations and societies are in turmoil, due to strife, warfare, inequity, and climate. We no longer can afford to think only about prevention, particularly in reference to climate change issues. We are in an era in which we must develop adaptation strategies in order to maintain any semblance of sustainability of life as we know it. In its *Global Sustainable Development Report*, the United Nations (2019) details the ways in which complex development issues have threatened the planet. While the need for building stronger communities, with an eye toward improved and more fluid adaptation (Rodin, 2014), has been apparent for some time, achieving sustainability is going to require transformational planning in order to address the effects of complex crises (Gates, 2021). Mental health professionals need to develop community-based strategies that can enable citizens to become aware of new and emerging challenges, learn how to respond, learn how to cope, learn how to adapt, and acquire new methods for sustainability. We have seen how trauma affects our very physiology and social behavior; this is why holistic and community-based interventions are so essential for adaptation and sustainable solutions to complex crises. We need to create systems that foster calm and promote prosocial behavior, so that we are responsive rather than reactive to our circumstances.

Building Resilience and Other Community-Based Trauma-Informed Strategies

Due to the collective nature of complex crises, it behooves us to think about the various relevant issues in terms of public health policies, which tend to prioritize prevention and strategic planning (Tarvydas et al., 2017; Terwindt et al., 2016). Of course, individual interventions are important, but even at the micro level, the efficacy of interventions needs to

be monitored and evaluated in order to inform strategies and policies and then continue to enhance prevention efforts (Schmets et al., 2016). A great deal of care has been taken, throughout this textbook, to provide rich information about clinical models and how to assist individuals experiencing crisis and trauma. Of necessity, we focus primarily on trauma-informed community-based interventions here.

One very promising model is the *Trauma-Informed Community Development* (TICD) model, which is presented in Chapter 19; therefore, we only reiterate a brief description here, so as to bring TICD into the discourse about responding to complex crises. TICD is a research-based model that the *Neighborhood Resilience Project* (NRP), located in Pittsburgh, Pennsylvania, designed and developed to engage community residents in a low-resource community (Abernathy et al., 2019). TICD works with neighborhoods and communities, block-by-block or at the micro-community level, to assess the physical and behavioral health of residents as well as the social health of each block or micro-community. The stakeholder-centered assessments are an instrumental part of NRP's effort, which has gained national and international attention. TICD is a culturally sensitive and context-specific model that uses grass-roots information from local stakeholders to conduct community-appropriate development. In response to demand, NRP now offers an annual *TICD Institute* that draws cohorts of community professionals from around the country whose agencies are interested in replicating the TICD model in their home communities. Most recently, NRP has been working to initiate and extend the TICD model into local schools, with an aim toward building a school-based TICD model that could be adapted for use in other parts of the state, country, and world. The community-building aspects of TICD entail many efforts that focus on building and sustaining resilience within low-resource communities. The TICD model is robust and has the systemic elasticity to be used in complex crises situations.

Resilience is an essential aspect of crisis prevention, mitigation, and recovery. Human resilience is responsible for individuals remaining intact—physically, emotionally, existentially, spiritually—in spite of facing horrific experiences. Resilience allows us to cope with crisis, adapt, and recovery quickly. Levers and Drozda (2018) have examined issues associated with complex trauma, from an ecological framework, and encourage counselors to respond from their professional stance of client empathy, but to move beyond traditional empathy to an embrace of compassion as a means of intervention. Especially when considering coupled human and natural systems, human intervention is an essential cornerstone for maintaining resilience, or the “capability to retain similar structures and functioning after disturbances for continuous development” (Liu et al., 2007, p. 1515). Human action is necessary for systems to continue functioning, in general, but human action also is needed so that systems remain familiar (Levers & Drozda, 2018). In other words, any system has a threshold or breaking point, at which the stress placed upon the system simply is no longer sustainable. Human action then becomes essential, in order to revamp systems that perpetuate inequity and thus engender trauma.

Teahen et al. (2017) have pointed to the interconnections within complex crises and the urgency of disaster preparedness, discussing the proactive need for building and enhancing social-ecological resilience. Rodin's (2014) notion of a “resilience dividend” has amplified the need to lay groundwork for helping communities, which have experienced disruption due to disaster and complex crises, to transform into communities that self-regulate with resilience. Rodin, further, has emphasized the importance of prevention as a public health imperative in building resilient communities as a forward-thinking effort to stave off the worst effects of complex crisis. Likewise, Gates (2021) has promoted an optimistic agenda of multilayered planning aimed at avoiding further disaster. In the face of complex crises, we need to facilitate the “new normal” as one of resilience, particularly as it offers guidance for intervention, at multiple levels, and aims at mitigating the impacts of anthropogenic climate change and other complex crises (Teahen et al., 2017). Saul (2013) has identified the following four themes in community resilience and recovery:

- Emphasizing the importance of building community and enhancing social connectedness
- Facilitating the collective story telling of community experience and response
- Reestablishing the rhythms and routines of life and engaging in collective healing rituals

- Reestablishing the rhythms and routines of life and engaging in collective healing rituals
- Arriving at a positive vision of the future with renewed hope (pp. 105–106)

CONCLUSION

The call to conceptualize multiple crises as complex and interwoven is urgent. In this chapter we have offered numerous examples of the interplay between complex crises and how individuals and communities may be swept up by forces that are not necessarily under their control, but very well may be manageable, with adequate planning and prevention efforts in mind. It is imperative for counselors and other helping professionals to consider the intersections of multiple and complex crises, moving away from the notion of crises occurring in an acute, isolated, and time-bound manner and moving toward a more expansive understanding of complex crises as catalysts for individual and systemic complex trauma. We hope that this chapter has provided invitations for assisting with this new conceptualization as well as offerings for how to address and respond to a confluence of crises.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Australian Bushfires Mental Health Resources:

<https://www.phoenixaustralia.org/resources/bushfires>

Duquesne University's Integrity of Creation site (Conference Archives and Other Climate Resources):

<https://www.duq.edu/events/integrity-of-creation>

“Earthrise” Video by Inauguration Day Poet Amanda Gorman

<https://www.ecowatch.com/amanda-gorman-earthrise-video-2650154337.html?rebellitem=1#rebellitem1>

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development" (Liu et al., 2007, p. 1515). Human action is necessary for systems to continue functioning, in general, but human action also is needed so that systems remain familiar (Levers & Drozda, 2018). In other words, any system has a threshold or breaking point, at which the stress placed upon the system simply is no longer sustainable. Human action then becomes essential, in order to revamp systems that perpetuate inequity and thus engender trauma.

Teahen et al. (2017) have pointed to the interconnections within complex crises and the urgency of disaster preparedness, discussing the proactive need for building and enhancing social-ecological resilience. Rodin's (2014) notion of a "resilience dividend" has amplified the need to lay groundwork for helping communities, which have experienced disruption due to disaster and complex crises, to transform into communities that self-regulate with resilience. Rodin, further, has emphasized the importance of prevention as a public health imperative in building resilient communities as a forward-thinking effort to stave off the worst effects of complex crisis. Likewise, Gates (2021) has promoted an optimistic agenda of multilayered planning aimed at avoiding further disaster. In the face of complex crises, we need to facilitate the "new normal" as one of resilience, particularly as it offers guidance for intervention, at multiple levels, and aims at mitigating the impacts of anthropogenic climate change and other complex crises (Teahen et al., 2017). Saul (2013) has identified the following four themes in community resilience and recovery:

- Emphasizing the importance of building community and enhancing social connectedness
- Facilitating the collective story telling of community experience and response
- Reestablishing the rhythms and routines of life and engaging in collective healing rituals
- Arriving at a positive vision of the future with renewed hope (pp. 105-106)

CONCLUSION

The call to conceptualize multiple crises as complex and interwoven is urgent. In this chapter we have offered numerous examples of the interplay between complex crises and how individuals and communities may be swept up by forces that are not necessarily under their control, but very well may be manageable, with adequate planning and prevention efforts in mind. It is imperative for counselors and other helping professionals to consider the intersections of multiple and complex crises, moving away from the notion of crises occurring in an acute, isolated, and time-bound manner and moving toward a more expansive understanding of complex crises as catalysts for individual and systemic complex trauma. We hope that this chapter has provided invitations for assisting with this new conceptualization as well as offerings for how to address and respond to a confluence of crises.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Australian Bushfires Mental Health Resources:
<https://www.phoenixaustralia.org/resources/bushfires>

Duquesne University's Integrity of Creation site (Conference Archives and Other Climate

Duquesne University's Integrity of Creation site (Conference Archives and Other Climate Resources):

<https://www.duq.edu/events/integrity-of-creation>

“Earthrise” Video by Inauguration Day Poet Amanda Gorman

<https://www.ecowatch.com/amanda-gorman-earthrise-video-2650154337.html?rebellitem=1#rebellitem1>

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CHAPTER 25

The Impact of War on Military Veterans

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CHAPTER OVERVIEW

The purpose of this chapter is to explicate the impact that war has on members of the military. In describing the effects of war on combat veterans and the challenges posed for those who return from war, potential needs for relevant mental health services are made explicit. The chapter identifies practice implications and offers an online list of resources for professionals working with military veterans.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

After reading this chapter, the reader should be able to:

1. Understand the diversity of populations within the military;
2. Develop awareness of the complexity of responses to war;
3. Learn ways to respond to the types of trauma that are experienced by veterans and to facilitate related recovery strategies;
4. Identify mechanisms for assisting with re-adaptation to civilian life and for building resilience among veterans; and,
5. Understand the counseling implications for working with veterans.

INTRODUCTION

This chapter focuses on the most salient factors that have an impact on military combatants and their experience of warfare. The circumstances and the environment associated with combat causes a set of complex and unique responses. Due to an immense diversity of experience, it is extremely difficult to identify all of the variables associated with human responses to warfare. This chapter is an *introduction* to the potential psychological jolts that war trauma has on the military combat veteran. There is a complex anatomy of human responses to war trauma to consider. Detailed in this chapter are five areas that reveal the complexity of this topic: (a) there are five major areas of research related to human responses to war trauma; (b) there are diverse populations of military personnel; (c) there are numerous and contrasting war experiences; (d) resilient individuals appear to adjust and reintegrate into daily society more easily; and (e) physiological brain structure changes occur in some veterans as a result of traumatic war experiences.

Readers will learn that post-trauma reactions are much more comprehensive than the label of anxiety disorder, and that traumatizing events affect the whole person. Physical adaptations, cognitive thought processes, emotional responses, behavioral changes, and subjective interpretations are all part of the psychological makeup of the person who experiences war trauma. Recovery, resilience, and reintegration are three major components in psychological adjustment following combat.

The devastating cost of warfare can be measured objectively through the number of lives lost, homes destroyed, damage to cities, agricultural carnage, and environmental destruction. The subjective and potentially devastating toll on the character of military combatants who experience the "sensory" reality of warfare is much more difficult to measure. Significant psychological, physical, emotional, and spiritual changes occur in individuals who experience traumatic war events. Permanent damage to a person's character does not have to occur following combat trauma. The purpose of this chapter is to identify the unique issues, problems, themes, and predictable human responses to military combat. This aim is accomplished through the discussions that appear in the major sections of the chapter that follow: (a) Historical Perspectives of Posttraumatic Stress Disorder (PTSD), (b) Psychosocial Context, (c) Complex Nature of Trauma Responses, (d) Treatment Modalities, and (e) Counseling Implications. These sections are followed by a summary of the chapter and an online-only list of relevant resources related to trauma and military veterans.

HISTORICAL PERSPECTIVES OF POSTTRAUMATIC STRESS DISORDER

Although the diagnosis of PTSD was not introduced formally until 1980, with the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association [APA], 1980)*, the notion of an emotional response to combat trauma has been around for thousands of years. Greek historian Herodotus provided an account of combat stress in his writings about the Battle of Marathon, in 490 BCE (*Marincola & De Selincourt, 2006*). Hippocrates described soldiers who experienced nightmares about combat (*Crocq & Crocq, 2000*). Dr. Jacob Mendez Da Costa noted that many Civil War veterans suffered from physical issues (e.g., palpitations, constricted breathing, irritation, increased arousal, and other cardiac symptoms) not associated with any wounds; this became known, variably, as "soldier's heart" and "Da Costa syndrome" (*Grinage, 2003*). Capt. Charles Myers (Royal Army

soldiers' heart and De Costa syndrome (Ornaghi, 2003). Capt. Charles Myers (Royal Army Medical Corps) documented incidences of soldiers who were experiencing a number of symptoms (e.g., anxiety, nightmares, tremors, impaired sight and hearing), which he described as "shell shock," because these symptoms began after being exposed to exploding shells on the battlefield (Alexander, 2010). The U.S. Department of the Army (1994), in World War II, identified "battle fatigue" as the successor to "shell shock," with symptoms similar to conditions previously identified (e.g., fatigue, anxiety, loss of concentration, depression, memory loss, decreased motivation, and other disturbances in physical functioning); the term "battle fatigue" subsequently was used until the aftermath of the Vietnam War.

Posttraumatic Stress Disorder

PTSD is significant in considering the effects of war on military personnel. As a diagnosis, PTSD gained widespread recognition in the aftermath of the Vietnam War, secondary to thousands of Vietnam veterans lining the halls of Veterans Affairs (VA) hospitals across the country (Dicks, 1990). Researchers became interested in learning about this new diagnosis, and in the early 1980s, Congress authorized the Vietnam Veterans Readjustment Study to determine the prevalence of PTSD in returning veterans as well as to identify problems with reintegration and adjustment, postdischarge (Kulka et al., 1990). According to Rosen et al. (2010), there have been over 12,000 studies in peer-reviewed journals related to PTSD.

Changing Criterion A

The *DSM-III* introduced PTSD, which was characterized as a cluster of symptoms, following a traumatic incident that most people would consider extreme or beyond normal. Traumatic stressors included rape, assault, combat, natural disasters, car accidents, airplane crashes, bombing, torture, and serious bodily injury. Without the traumatic events, as defined within *Criterion A*, a diagnosis of PTSD could not be made. In this sense, *Criterion A* served as the gatekeeper for the diagnosis of PTSD.

With the introduction of *DSM-IV* (APA, 1994), the emphasis in *Criterion A* shifted to components of the person's response to the specific traumatic event. In order to be diagnosed with PTSD, a person had to have experienced fear, helplessness, or horror in response to the trauma. Subsequently, in *DSM-5* (APA, 2013), *Criterion A* once again underwent revisions. In addition to having directly experienced the traumatic event or witnessed the traumatic event as it occurred to others, *Criterion A* included a category of having learned that the traumatic event occurred to a family member or close friend; it also established a category for individuals who repeatedly experienced exposure to aversive details of the traumatic events (e.g., first responders). The concept of having to experience fear, helplessness, or horror in response to the traumatic event was removed in *DSM-5*. Rosen et al. (2010) noted that research has continued to challenge the way we understand and subsequently treat PTSD. The changes in *Criterion A*, over time, have reflected the challenges and criticisms noted through research and debate over the years. It is unknown how PTSD will evolve, if at all, in the years to come; however, it is important for clinicians and researchers alike to continue to question what we know about PTSD, in order to ensure the validity of the diagnosis.

PSYCHOSOCIAL CONTEXT

Many male and female veterans of the U.S. military returning from the Vietnam War suffered from a problematic readjustment to civilian life (e.g., Buck, 1998; Ettegedgui & Bridges, 1985; Evans & Sullivan, 1990; Everstine & Everstine, 1993; Figley, 1978; Goodwin, 1987; Herman, 1992; Sandeck, 1987; Strayer & Ellenhorn, 1975; van der Kolk, 1984, 1987, 1989; Williams, 1987). The unconventional warfare unique to Vietnam is thought to have caused an estimated 500,000 psychological casualties among soldiers, sailors, and airmen. Lack of popular support for the war in conjunction with war protests is considered a major contributor to problematic psychological adjustment of Vietnam veterans (Buck, 1998; Scott, 1993; Wilson, 1978).

With the appearance of PTSD in the *DSM-III* (APA, 1980) in 1980 came a change in focus.

with the appearance of PTSD in the *DSM-III* (APA, 1980) in 1980 came a change in locus. Psychological symptoms were first attributed to the traumatic events instead of individual weakness (Friedman, 2003). This new diagnosis recognized the potential for long-lasting psychological problems as a direct result of a specific trauma event or events (Fairbank et al., 1993). The uniqueness of PTSD is its direct link to an etiological stressor or trauma event (Breslau, 2002; Breslau et al., 1995). War is a traumatic event, and the predictable psychosocial responses and unique phases of adjustment are discussed in this chapter.

Understanding Psychosocial Responses to War

In 1983, a congressional mandate prompted further investigation of PTSD and other postwar psychological problems among Vietnam veterans. The National Vietnam Veterans' Readjustment Study (NVVRS) was conducted to obtain data identifying the prevalence of postwar psychological problems. The prevalence of PTSD among "Vietnam theater veterans" (veterans deployed to the war zone) was an estimated 15.2% (male) and 8.5% (female). Those individuals who had higher war zone exposure to the "sensory" reality of warfare had higher rates of PTSD at 35.8% (male) and 17.5% (female; Schlenger et al., 2002).

Table 25.1
Veterans Affairs/Department of Defense Classification System for Traumatic Brain Injury Severity

	Mild	Moderate	Severe
Glasgow Coma Scale	13–15	9–12	≤8
Loss of consciousness	0–30 min	30 min to 24 h	More than 24 h
Posttraumatic amnesia	Less than 24 h or none	More than 24 h - less than 1 week	More than 1 week
Alteration of consciousness/ Mental state	A moment up to 24 h	>24 h	>24 h

Source: Data from U.S. Department of Veterans Affairs & Department of Defense (2016). *VA/DoD clinical practice guideline for the management of concussion—mild traumatic brain injury*. Report prepared by the Management of Concussion—Mild Traumatic Brain Injury Working Group. <https://www.healthquality.va.gov/guidelines/rehab/mtbi/mtbicpgfullcpg50821816.pdf>

More than 2.77 million U.S. troops were deployed in support of Operation Iraqi Freedom (OIF; Iraq) and Operation Enduring Freedom (OEF; Afghanistan), beginning as early as October 2001 (Wenger et al., 2018). The all-volunteer force experienced an unprecedented pace of deployments, including multiple deployments to combat with infrequent breaks between deployments (Belasco, 2007; Bruner, 2006; Hosek et al., 2006). There were more than 5.4 million deployments by those 2.77 million service members (Wenger et al., 2018). Fewer casualty rates (killed and wounded) for these deployments were due to advances in medical technology and the use of body armor (Regan, 2004; Warden, 2006).

Psychological and stress reactions have developed in soldiers because of the following factors: multiple deployments, dangers of combat as exemplified by improvised explosive devices (IEDs), and exposure to the uncertainties associated with nonconventional guerilla warfare. There have been a range of estimates of mental health problems among OIF and OEF veterans over the years. In 2008, a RAND corporation monograph (Tanielian & Jaycox, 2008) indicated that of OIF and OEF veterans, 14% screened positive for PTSD, and 14% screened positive for major depression. Another 19% reported a probable traumatic brain injury (TBI) experience. In the 2017 VA Health Care Utilization report (Veterans Health Administration, 2017), OEF/OIF veterans made up approximately 10% of the more than 6.6 million veterans receiving care through the VA. Approximately 58% of the OEF/OIF veterans receiving care through the VA were noted to have been diagnosed with a mental disorder. PTSD, depression, and neurotic disorder accounted for approximately 38% of the mental disorders treated through the VA. The Defense and Veterans Brain Injury Center (DVBIC) indicate that over the 20-year period of 2000 to 2020, a total of 430,720 military veterans

have experienced a TBI with the vast majority (nearly 355,000) being mild TBIs (as cited in [U.S. Department of Veterans Affairs, 2021](#)). Traumatic brain injury can be categorized broadly as penetrating or nonpenetrating, and as focal or diffuse. A penetrating injury occurs when an object pierces the skull and enters the brain tissue. A closed head injury (nonpenetrating injury) causes the brain to move within the skull and collide with the bone. A focal injury occurs when a specific area of the brain is injured, whereas a diffuse injury occurs over a large area of the brain. TBIs are classified as mild, moderate, or severe. The classification system used by the VA/DoD appears in [Table 25.1](#).

Phases of Adjustment

As the military continues its rapid schedule of deployments, the ever-increasing psychological casualty statistics continue to reflect the physical, cognitive, emotional, behavioral, and spiritual (PCEBS) costs of warfare among our combat veterans. The immediate impact of the war may not be debilitating for many, but there is evidence that soldiers who witness horrific events are at risk for chronic mental health problems over their life-span ([McFarlane, 2015](#); [National Center for Posttraumatic Stress Disorder \[NCPTSD\] & Walter Reed Army Medical Center \[WRAMC\], 2004](#)). PTSD symptoms are only some of the many manifestations of traumatic war experiences. An extensive library of related research is available online and explores such war experiences in detail (see U.S. Department of Veterans Affairs as well as NCPTSD in the online-only Resources section).

Symptom intensity, rate of recovery, and support needs for each veteran are all part of an elaborate and personally meaningful reintegration process that varies for each military veteran. Human traumatic response includes an intricate array of factors, and the complexities of human responses to military combat, relevant issues, and evidence-based practices are explored in the following section.

COMPLEX NATURE OF TRAUMA RESPONSES

Human beings respond to danger through a “complex, integrated system of reactions, encompassing both body and mind” according to [Herman \(1992\)](#). When attempting to assess the impact that crisis experiences have on the individual, the evaluator needs to consider three “interactive components” ([Webb, 1991](#)). According to Webb, the three components that determine individual responses to traumatic events are the following: (a) individual factors, (b) the nature of the crisis events, and (c) factors in the support system. Herman and Webb’s early PTSD research provide an historical basis to organize and conceptualize more recent research findings.

There are five major research areas of human traumatic response to warfare: (a) Personal Characteristics of the Individual to Consider, (b) Psycho-Physiological and Other Somatic Factors to Consider, (c) Social Factors to Consider, (d) Characteristics of the Trauma Events to Consider, and (e) Treatment Modalities. These are discussed in the text that follows.

Personal Characteristics of the Individual to Consider

There are significant personal variables that determine an individual’s responses to traumatic events, such as age, sex, cognitive level of function, moral and spiritual beliefs, previous trauma experiences, pre-crisis adjustment, cultural beliefs/background, and previous behavioral health issues ([Buck, 1998](#); [Janoff-Bulman, 1992](#); [Herman, 1992](#); [Webb, 1991](#)). In fact, an individual’s risk factors serve as a strong predictor of who develops PTSD and who does not ([Rosen et al., 2010](#)). While many risk factors of PTSD do not inform treatment of PTSD, [Meyer et al. \(2019\)](#) note that psychological inflexibility, which is the inability to shift mental or behavioral repertoires in accordance with varying situational demands, is a modifiable factor that can be targeted in treatment; psychological inflexibility may predict PTSD symptom severity.

Included within the factors under discussion here are subjective influences that are difficult to identify and categorize objectively. Students of trauma must recognize these subjective

to identify and categorize objectively. Students of trauma must recognize these subjective issues in order to gain a more comprehensive understanding of the human responses to traumatic war events. Three subjective existential issues are discussed in the following subsections: The Psychology of Warfare, Conceptualization of War, and Resistance to Killing.

The Psychology of Warfare

There is a myriad of psychological, economic, and social group theories that aim to explain why nations and human beings find it necessary to go to war (LeShan, 2002). Two major existential concepts related to the psychological response to warfare are examined here. First, LeShan argues that the manner in which nations and individuals conceptualize warfare should be studied as a way of understanding the underlying psychology of warfare. He believes that understanding how people conceptualize war leads to a deeper understanding of the function of war and the meaning that individuals and governments construct from participating in war. Second, Grossman (2009) suggests that there is a basic human resistance to killing another human being. To become more efficient in war and kill more of the enemy, contemporary military and police training methods differ from those used prior to the Korean War. Because of these training changes, soldiers of today are more likely to kill during combat than the soldiers in World War II and in previous wars. Grossman suggests that focusing on efficiency in killing has resulted in more severe psychological damage to the modern soldier. Both authors emphasize that the existential as well as the trauma-specific issues that arise are important. Sensory combat experiences must be processed and incorporated within the individual's perceptions and understandings of those objective events. LeShan and Grossman provide a framework for understanding the subjective interpretations that human beings make as a direct result of the objective experiences of war.

Conceptualization of War

LeShan (2002) suggests that the various psychological, economic, and social group theories of why nations and individuals allow themselves to get involved in war are limited in their views about the causes of warfare. He articulates the existence of a new conceptual framework that previously has been unavailable and unexplored. For the past 40 years, a new field of thought has developed that examines the diversity of how human beings perceive reality (LeShan, 2002). Perceptions of reality are altered when one nation goes to war with another. These perceptions do not necessarily represent the truth about the world and its structure; they are just perceptions. Perceptions that allow for warfare to develop are based on a bias or belief system that may or may not be accurate. To comprehend the full psychological motivation behind the behavior of warfare, LeShan asserts the centrality of basic human "drives," which potentially lead to the belief that war is the only way to resolve conflicting beliefs. In his book, *The Psychology of War*, LeShan explores human beings and the psychological tension of being a separate and unique individual, while simultaneously feeling the need to be accepted and to belong to a group.

LeShan (2002) refers to the Roman mystic, Plotinus, who suggests that we have an "amphibious nature" (LeShan, 2002, p. 27), and that we must find a strategy to integrate both the way of the one and the way of the many. War is one method in which human beings simultaneously can fill these fundamental needs. When a group/nation has the following three perceptions about the world and about another group/nation, then they have the necessary conditions to see war and violence as a viable option: (a) there is an enemy nation that is evil, and if they were destroyed, then the world would be a better place; (b) glory can be realized if action is taken against this evil enemy; and (c) everyone within the "tribe" must agree with this understanding about the evil enemy, or they are seen as a traitor to the group. If these three danger signs are present, then armed conflict may result.

What is created by the previous perceptions is a "mythic reality" of war, one in which a nation and its populace rally around a cause for the eradication of evil. This is what the nation perceives, but it is not at all what the soldier experiences. The combat soldier experiences the "sensory reality" of warfare. Initially, soldiers go into battle with the same mythic reality that is held by the larger populace, of which they are members. However, the soldier is faced with the visceral horrors of war; the senses are overwhelmed with the sights, sounds, smells,

tastes, and touches of war. There is a crisis in perception, due to the incongruence associated with the mythic reality of war and the sensory experiences to which the soldier is subjected. There is a series of expectations or beliefs associated with the mythic reality. The soldier expects to engage an evil enemy and, along with their fellow soldiers, survive. When a soldier witnesses the death and suffering of fellow soldiers, it does not fit the expectations associated with the mythic reality.

The death or severe injury of a fellow soldier is seen as a violation of the mythic rules of war. Within the mythic reality, there are two sets of morals. Soldiers judge the killing and combat behavior of enemy soldiers as evil. Killing the evil enemy is acceptable, righteous, virtuous, and good. The more time a soldier spends in sensory combat, the more quickly the mythic reality begins to erode. Witnessing unconventional combatants such as women and children participating in the killing does not fit into the mythic reality of war. For U.S. military soldiers to kill women and children, even if it is in self-defense, takes its toll on the sensory perceptions of moral constructs associated with acceptable combat. When confronted with sensory warfare, soldiers begin to question why the country is at war, along with their own participation in the fighting and killing. Once a soldier is unable to maintain the mythic reality that the nation uses to justify the killing, then a "meaning" or "spiritual" crisis occurs, and the soldier can no longer justify their personal participation in killing, combat, and warfare.

The individual soldier's perception of the "evil enemy" is potentially transformed into recognizing that the people being killed are human beings. The "glory" of killing the evil enemy begins to fade, and the "sensory reality" (sights, sounds, smells, taste, and touch senses of death and destruction) begins to permeate the soldier's total awareness. Disenchantment replaces the mythical cause. Combat soldiers experience these changes in an environment of misunderstanding. Military planners and the nation's populace do not fully understand the sensory experiences of combat soldiers and the resulting shift in their perceptions. Because of this difference in perception, many combatants tend to isolate themselves both emotionally and physically. As a result, war's objective experiences begin to invade, wound, and transform the soldier's spirit and subjective understanding of self, others, and the world. These objective sensory experiences erode the "mythic beliefs," and the combat veteran struggles with understanding life events in an environment of self-imposed isolation.

Every human characteristic that the individual attributes to a sense of "self" must be reshaped in order to make sense out of seemingly senseless sensory experiences. The cognitive dissonance between the individual's sense of self and the actuality of the sensory experience can be illuminated, and thus better understood, by considering the personal characteristics presented in [Box 25.1](#).

BOX 25.1

Clinical Insights: Personal Transitions

Human characteristics, involving the tensions between subjective- and objective-world experiences, include the following transitions:

- How the individual perceives personal power and control;
- Perceptions about the world and safety;
- How the mind organizes information;
- Alterations in the mind's total functioning;
- How an individual loves, relates, and connects intimately with others;
- What the individual believes about the world and about the self;
- Which values and ethical beliefs come into question;
- What is judged as good and evil;
- What is right and what is wrong; and,
- What is feared and what is loved, which becomes confusing.

It is important for the student of war trauma to realize that there is a deep personal transformation that soldiers go through as a result of the sensory experiences of warfare. This transformation cannot be explained fully by using just one label such as PTSD. Reactions to combat and war trauma are definitely a stress reaction to traumatic experiences, but it is potentially an identity and whole-person crisis, depending on a complex set of factors that is explained in the following section.

Resistance to Killing

Comprehending the human responses to war requires a fuller realization and understanding of the psychology behind the human capacity to create and conduct warfare, and, more specifically, the killing of another human being. In his book, *On Killing*, Lt. Col. Dave Grossman indicates that there is a significant psychological factor in most human beings, describing it as "an intense resistance to killing their fellow man. A resistance so strong that in many circumstances, soldiers on the battlefield will die before they can overcome it" (Grossman, 2009, p. 4). He refers to U.S. Army Brigadier General S. L. A. Marshall's experience and inquiry/questioning of World War II veterans and the fact that "only 15% to 20% would take any part with their weapons" (as cited in Grossman, 2009, p. 3). According to Grossman, the lack of enthusiasm for killing "causes soldiers to posture, submit, or flee, rather than fight; it represents a powerful psychological force on the battlefield; and it is a force that is discernible throughout the history of man" (Grossman, 2009, p. 29). He explains that "looking another human being in the eye, making an independent decision to kill him, and watching as he dies, due to your action, combine to form one of the most basic, important, primal, and potentially traumatic occurrences of war" (Grossman, 2009, p. 31). Marshall's research with World War II (WWII) veterans revealed that many soldiers fired in the general direction of the enemy, in an attempt to appear as if they were participating in killing enemy soldiers, and that most would not openly admit that they resisted the opportunity to kill the enemy.

Many soldiers during WWII openly volunteered to reload weapons for others, but the actual act of killing another human being was performed by approximately one-fifth of our U.S. combat soldiers (Marshall, as cited in Grossman, 2009). Those soldiers who fired weapons that were designed to kill from a distance such as mortar, rocket, cannon, or aircraft had a very high rate of participation, because they were not face to face with their enemy. So until the Korean and Vietnam wars, it is estimated that only about 20% of our military combat-experienced infantry veterans actually shot at and intended to kill enemy soldiers.

According to Grossman (2009), Marshall's findings largely have been ignored by the academic fields of psychology and psychiatry, but the U.S. Army has taken Marshall's discoveries seriously, and after the end of World War II, instituted several new training methods. Because of these training changes, various studies of Korean War veterans indicated a jump to a 55% firing rate, and in Vietnam, the firing rate increased to between 90% and 95%. The programming or conditioning methods used to train troops, which increased the firing rate for Vietnam War veterans, was classical and operant conditioning. Training methods included the following strategies: desensitization, conditioning, and denial defense mechanisms.

In the desensitization process, the idea of "killing" an enemy who is evil, different, and dehumanized begins as early as boot camp and continues throughout the training process. By dehumanizing the enemy and continuously making them appear evil, the soldier has little resistance to killing when the opportunity presents itself. Conditioning occurs with repeated practicing of "quick shoot" on a firing range that includes human-shaped targets. There is competition and also immediate gratification when the target falls or explodes. There is continuous reinforcement when the shooter is recognized by superiors and peers as an expert shooter. Expert shooters often graduate with honors from the training program and receive further reinforcement with other forms of personal recognition. Failure to complete the firing range activities results in delay of graduation and possible chastising by peers and superiors. There is extensive rehearsal, with nearly exacting battlefield conditions. Soldiers are taught to shoot reflexively and instantly as they "engage" the target. The word "engage" of course

means to “kill” the enemy. The word “target” is used to represent the human enemy. This neutralizing, dehumanizing, and denial-based language originates in training but also carries over into combat. This nonspecific language becomes a part of combat. Soldiers have rehearsed shooting at “the target” so many times that when they actually shoot at a human being, they are just “engaging a target.”

Psycho-Physiological and Other Somatic Factors to Consider

Significant investigations have been conducted regarding how the body responds to the extreme stresses that are associated with traumatic experiences; some of this research shows that the body's complex biochemistry becomes deregulated. Brain chemicals designed to protect us may become harmful due to the amount or dosage our body creates. The alertness of the brain, memory enhancement, and rapid heartbeat caused by increases in norepinephrine and epinephrine (adrenaline) benefit the human being as the fight-or-flight response to danger. Too high a level of these chemicals may cause learning and memory impairment and may induce confusion. The repeated infusion of excessive amounts of these chemicals appears to sensitize brain chemistry and results in increasing amounts of adrenaline release at lower stimulation thresholds. Emotional reactivity caused by the dysregulated nervous system results in hypersensitivity, exaggerated behavior responses, and more intense susceptibility to sensory triggers such as smells, sounds, and sights. This overabundance of chemicals potentially triggers a cinematic, even seizure-like, reliving of trauma referred to as a *flashback* (van der Kolk, 1984, 1987, 1989, 2014; Vasterling & Brewin, 2005). The negative effects of high levels of these chemicals may occur immediately following traumatic events and continue for a long time.

In addition to the chemical influences within the brain, there is also potential damage to the structure of the brain. Long-lasting damage to the hippocampus may occur, which is then linked to the development of short- and long-term memory. There is a significant 8% reduction in hippocampus size among military trauma victims ages 18 to 24 years (Bremner et al., 1995, 1997, 2002; Villarreal et al., 2002). In a related study of women with a history of childhood sexual abuse, there was a 12% decrease in left hippocampal volume (Bremner et al., 2003). Symptoms of PTSD are more pronounced for those individuals with a smaller hippocampus (Bremner, 2001; Gilbertson et al., 2002; Osuch et al., 2001; Shin, Orr, et al., 2004; Shin, Shin, et al., 2004). High cortisol levels have been linked to hippocampus shrinkage; as a result, high levels of cortisol, for longer and more chronic periods of exposure to danger, potentially produce more and longer-lasting damage to the brain. If the body attempts to compensate for this overuse of cortisol, and levels are over-reduced, the outcome could be brain-cell death in the dentate gyrus region of the hippocampus, where long-term memory and recall are created (Vasterling & Brewin, 2005). The potential symptoms that manifest as a result of this brain damage are fragmentary memories, amnesia, short-term memory lapses, verbal recall deficits, dissociation, and an inability to describe horrific experiences (Vasterling & Brewin, 2005; van der Kolk, 1984, 1987, 2014). These are just a few examples of brain chemistry alteration and structural brain changes due to chronic traumatic stress. In addition, recent insights drawn from Polyvagal Theory highlight the functions of the autonomic nervous system; Polyvagal Theory also illuminates the potential for impaired social engagement as an additional component of how trauma affects brain function, thus emphasizing the interrelationship between psycho-physiological and social factors (Porges, 2009, 2011).

Social Factors to Consider

A significant support strategy for recovery from traumatic experiences entails the social network available to combat veterans such as nuclear family, peers with shared experiences, supportive others, churches, school/educational institutions, personal friends, and extended family members. Military support systems are a unique population with variables significantly different than any other organization (Buck, 1998, 2012; LeShan, 2002; Tick, 2005, 2014; Wilson, 1978). Some of these unique circumstances are presented here so that the military

reached an all-time low of 500,000 soldiers. The military of today is much more diverse than at any other time in U.S. history. For example, there are ethnic minorities ranging from 24% in the Air Force to 40% in the Army, and 16% of all active-duty military personnel are women. Over 50% of all military personnel are married, and 11% of those are married to other military service members (NCPTSD & WRAMC, 2004). Recent data show that in 2014, ethnic minorities constituted 22.6% of the total veteran population in the United States, and it is expected that by 2040, minorities are projected to make up 35.7% of all living veterans (U.S. Department of Veterans Affairs, 2017a). According to a publication by the Brookings Institution, "While the U.S. military today has never had a higher fraction of women, they remain just 16% of the total force" (Robinson & O'Hanlon, 2020).

Several different components exist within the five major military organizations of the Army, Navy, Marine Corps, Air Force, and Coast Guard. Because of the Global War on Terrorism (GWOT), many National Guard and Reserve units from all five branches of the military have been called to active combat duty multiple times. Several resources available on soldiers' home bases support regular military units and their families who often reside either on those bases or in the immediate area. Because of geographic distance, a military base does not routinely support reserve units. National Guard and Reservists' families are isolated from military supports while the service member is deployed. Deployed reservists and/or guardsmen often lose their jobs or experience financial loss when they return from combat. More detailed information related to deployment, family issues, and unit integrity are examined in *The Iraq War Clinician Guide*, Second Edition (NCPTSD & WRAMC, 2004) and should be reviewed by any professional who anticipates working with military war veterans.

Characteristics of the Trauma Events to Consider

There are many aspects of the specific traumatic event that may influence the response that an individual has to the event. The diversity of war and military experiences has a major impact on individual responses. For example, if the individual is exposed to a single traumatic event, the symptoms associated with this event are potentially less debilitating than chronic and long-term recurring events (Buck, 1998, 2012; Herman, 1992). The individual who experiences a single-event trauma may feel "not him/herself," while the chronic trauma victim may feel a total and irreversible loss in sense of "self" (Herman, 1992). If trauma is experienced in solitary, the individual may feel unprotected, alone, and abandoned; hence, the option of social supports, through a shared experience, may not be available to this person. There is also a direct correlation between the severity of loss and the number and intensity of symptoms that develop (Everstine & Everstine, 1993; Zimmerman et al., 2018).

Certainly, the loss and death of a family member or friend can intensify the trauma symptomatic response. Variables that determine how survivors react to death include the following: death due to misconduct or natural causes, age of the deceased, and circumstances related to the death. The most devastating psychological trauma occurs when the survivor believes that they contributed to death due to neglect, misconduct, or intent (Buck, 1998, 2012).

Other issues to consider relate to the nature of the trauma. These include the following factors: the proximity and level of exposure to the traumatic event; the presence of a loss in status, personal power, and control; and the loss of bodily function through physical injury or pain. During military operations, there are a multitude of differing experiences with which the individual soldier may be faced; these include pre-deployment, deployment, types of conflict, medical evacuation, psychological stresses and responses, psychiatric care needs, post-deployment, administrative discharges, and so forth (NCPTSD & WRAMC, 2004).

This subsection of the chapter focuses on the types of conflict that military combatants must endure and their psychological responses. Different experiences that occur in warfare include low-intensity combat, high-intensity combat, terrorist activities and guerilla warfare tactics, war zone stressors, moral injury considerations, other unique issues, and military sexual trauma. Human responses to these various experiences differ significantly.

Low-Intensity Combat

Low-intensity combat in a wartime or combat environment, where fear of death or injury is less imminent, often includes a chronic strain on the individual. The person is subjected to harsh living conditions, family separation, extremes of hot or cold, and long hours of being on duty with little to no respite. The combatant experiences isolation, minimal communication with family, boredom, and a chronic awareness of the potential dangers that exist in this environment. These human stressors often foster the development of mood and anxiety disorders, separation anxiety, and adjustment and personality crises. Preexisting conditions may be exacerbated by this level of combat. Development or recurrence of alcohol and drug abuse may occur, depending on availability of these substances.

High-Intensity Combat

Intensive combat includes emotional responses to combat experiences. These often are viewed in a multiphase trauma response continuum (NCPTSD & WRAMC, 2004), as described in the text that follows.

Immediate Phase

The immediate phase of response includes "normal" and predictable reactions to extreme stressors and would include disbelief, strong emotions, confusion, fear, and autonomic arousal and anxiety. Various forms of adjustment disorder or maladaptive traits often manifest during this phase due to the extreme nature and immediacy of combat. Any preexisting conditions may be exacerbated, such as depression, previous PTSD symptoms, and substance abuse. Additional issues related to nonconventional warfare such as biological agents and chemical warfare can add additional disruption in the life of a military combatant (DiGiovanni, 1999).

Delayed Phase

The delayed phase occurs following intense combat stressors and may result in unexplainable physical symptoms or other PTSD symptoms, followed by substance abuse. These symptoms might include persistent autonomic arousal characterized by somatic symptoms, intrusive recollections, irritability, apathy, persistent anger, dissociation, mourning, and social withdrawal (NCPTSD & WRAMC, 2004).

Chronic Phase

The chronic phase includes continued arousal and intrusive symptoms with infusion of existential questions and personal discovery. A mix of depression and anxiety or other mood disturbance often manifests during this phase. Substance abuse may become more entrenched, legal problems may emerge, and pervasive distrust of self and others often develops. Due, in part, to this lack of trust, many combat veterans avoid all reminders of the traumatic events and isolate themselves both physically and emotionally. In this phase, the individual is attempting to make sense out of senselessness and is assigning some form of meaning to the objective events that have been experienced (Buck, 1998, 2012; DiGiovanni, 1999; NCPTSD & WRAMC, 2004).

Terrorist Activities and Guerilla Warfare

The increase in hypervigilance and stress related to tactics of terror such as remotely detonated explosive devices, car bombings, and mortar and rocket attacks cause additional psychological stress for the individual. The fear and surprise associated with this kind of warfare takes a psychological toll on an individual's sense of power and control within their environment. A crisis of meaning and senselessness begins to invade the individual's sense of purpose for being in this environment. Enemy combatants often are not readily identifiable, as civilian women and children often participate in this type of warfare. Not having a clearly identifiable enemy, coupled with uncertainty and doubt as to personal power to keep self and

...fellow soldiers safe, causes the soldier to remain ever vigilant and on guard (NCPTSD & WRAMC, 2004).

War Zone Stressors

War-zone stressors do not solely develop from combat actions alone, but may also arise from various types of demands, stresses, and traumatizing events. Veterans complain about a lack of preparedness for their deployment or a lack of sufficient training for their deployment. They may note having the wrong equipment or broken-down equipment to complete their mission. These veterans are likely to note a greater feeling of helplessness and unpredictability in the war zone. Surveying the aftermath of combat operations may include seeing the remains of civilians, enemy forces, and U.S. or allied personnel. Veterans are likely to disclose seeing homes and whole villages destroyed and smelling the decaying bodies of humans and animals killed in action. Living conditions and overall work environment provide constant stress. Lack of creature comforts, inability to take a shower, uncomfortable climate, long workdays, and lack of privacy all take a toll on the individual. While deployed in a combat zone, service members are likely to report ongoing concerns about their families back home. Individuals who deploy as members of the National Guard or Reserves often leave higher-paying civilian jobs, which can put a strain on family finances and relationships. Service members who are single parents face an additional strain of placing their children with others and oftentimes missing out on key developmental moments in their children's lives (NCPTSD & WRAMC, 2004).

Moral Injury Considerations

According to Maltzahn (2020), "Moral Injury (MI) is a set of symptoms that revolve around questioning one's self, beliefs, life's meaning, and ideals causing intense guilt, shame, doubt, inferiority, or internal turmoil" (p. 17). MI results from exposure to a traumatic event that violates deeply held values and moral beliefs, which results in a number of emotions such as guilt, anger, and shame. It is the act of engaging in an activity that goes against one's underlying moral values and beliefs (e.g., "you don't kill women and children" or "thou shall not kill") that results in the injury to one's moral values and beliefs, which causes an emotional response such as anger, shame, or guilt. The notion that war fighters faced moral dilemmas is not new, but the advancement of guerilla warfare and terror tactics in urban areas has brought to the forefront the increased rate of such events. According to Farnsworth et al. (2014), about 25% of Army soldiers and Marines have encountered at least one situation in which they had to make a moral decision, and they were unsure how to act. Veterans experience emotionally painful emotions such as guilt, shame, anger, disgust, and contempt, which then must be repaired.

Other Unique Issues to Consider

U.S. military forces must follow rules of engagement, especially while fighting where civilian populations are present. To limit civilian casualties, the U.S. military command structure requires justification for each violent interaction with the enemy. All fighting incidences are subject to retrospective analysis by command leadership. Commanders often require post-action justification of violent action taken against an enemy. Many soldiers see this process as ridiculous and accusatory. If the combatant interprets the retrospective review in this manner, then the military commanders may appear uncaring, unreliable, and unsupportive. The combatant who feels betrayed by command often experiences more severe psychological symptom development (Grossman, 2009).

There are incidences in which U.S. military units mistakenly fire on their own personnel, resulting in injury and death. Incidents of "friendly fire" have occurred because of miscommunication, error, and confusion on the battlefield. Those who are responsible for such friendly fire incidences, as well as the victims of these mistakes, potentially suffer more negative perceptions about the war. It is very difficult for soldiers to make sense out of the war and its purpose when a military action or mistake costs the lives of fellow soldiers (Buck, 1998, 2012; Grossman, 2009; Tick, 2005, 2014).

Military Sexual Trauma

The U.S. Department of Veterans Affairs (VA, 2017b) uses the term “military sexual trauma (MST),” which is defined as “physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training” (38 U.S. Code Sec. 1720D). As reported in the *Iraq War Clinician Guide*, the Department of Defense (NCPTSD & WRAMC, 2004, p. 66) conducted a study in 1995 and found that the sexual harassment rate for women was 78%, and for men it was 38%. Sexual assault, both attempted and completed, was 6% for women and 1% for men. According to Barth et al. (2016), approximately 41% of women and 4% of men reported experiencing MST. The authors noted that 41% of women had experienced sexual harassment, and almost 4% of men had experienced sexual harassment. Other studies, conducted by the Veterans Administration and reported in the *Iraq War Clinician Guide*, indicate that female veterans reported sexual assault rates as high as 23%. Other studies (NCPTSD & WRAMC, 2004) suggest that the rates of sexual assault among active-duty military personnel are higher during wartime than peacetime. Barth et al. did not find an association between MST and deployment to a combat zone among women veterans; deployed men to a combat zone had lower risk of MST compared with nondeployed men. Sexual assault victims experience higher rates of lifetime PTSD symptoms. Trauma (PTSD) symptoms among male victims of sexual trauma last across the life-span at 65%, which is higher than combat-related PTSD, at 38.8%. Female victims of sexual assault have lifetime symptoms of PTSD at 46%. Sexual trauma occurs most often where the victim works or lives. In many cases, the victim must continue to live or work with the perpetrator or friends of the perpetrator. Potential impact on the victim includes the disruption of career goals, low performance evaluations, delayed promotions, continued contact with the perpetrator because of unit mission, and the need to maintain unit cohesion (NCPTSD & WRAMC, 2004).

Treatment Modalities

Before identifying the “best practice treatment methods” for military veterans, it is important to understand who is being treated. The need for accurate and comprehensive assessment cannot be overstressed when evaluating the individual’s personal attributes (strengths/weaknesses) as well as the specifics of the traumatic event. Ethical practices, which include sensitivity to diversity and multicultural issues, must be used in the assessment, diagnosis, and mental health treatment of active-duty service members, veterans, and military families (Stebnicki, 2021).

It is important to assess the level and intensity of exposure, the type of experience, the duration of the experience, and the social supports that are already being provided or that may be available. It is extremely important to recognize the possibility of TBI caused by explosions, impact wounds, and other concussion-type experiences. The OEF and OIF campaigns have been identified as the TBI wars, and symptoms related to this type of injury can be temporarily or totally debilitating (Chemtob et al., 1998; Cifu et al., 2010).

According to Vaughn et al. (2014), the prevalence rate of PTSD and major depressive disorders among OEF/OIF veterans consistently has been higher, when compared to other generations of veterans; however, there has been a wide range of prevalence rates (1.6%–60%), according to a meta-analysis completed by Fulton et al. (2015). This range has been attributed to a number of factors including methodology, anonymity of reporting, method of diagnosing PTSD, military occupational specialty, and level of combat exposure. Military members may be reluctant to disclose PTSD-related symptoms out of fear of reprisal from peers and supervisors alike (Hogue et al., 2004). Fulton et al. concluded that the prevalence rate of PTSD in OEF/OIF veterans was 23%, which was lower than the 30% rate within the Vietnam veteran population (30%) but higher than the general population (8.7%). The environment often determines the subjective and somatic responses that an individual may have. For example, veterans of the OEF and OIF campaigns have been subjected to the following stressors: extended periods of constant stress; unavailability of any “safe zone”; constant exposure to danger (mortar/rocket attack and explosive devices planted along road

constant exposure to danger (mortar/rocket attack and explosive devices planted along road and walkways); constant “hyperarousal”; a rigid, highly structured military environment; exposure to multiple types of terrorism; and an enemy not readily identifiable (women or children combatants). Because this type of environment requires constant hypervigilance, soldiers are often too exhausted to process war events, emotionally and psychologically, until they leave the battlefield.

Many soldiers report a hypnotic aspect to war and combat. Combat is perhaps the most exhilarating and energizing experience of a soldier’s life. While witnessing and participating in multiple atrocities of warfare, they have experienced the excitement and thrill of combat. The ethical and spiritual incongruence of witnessing death and destruction, while simultaneously experiencing the physiological excitation of warfare, is difficult for many combat veterans to assimilate. They struggle with coming to terms with their own emotional responses of excitement in an environment in which they witnessed and felt the moral decay of a society through death and destruction (Grossman, 2009).

Another poignant actuality of war relates to psychiatric and psychological casualties and the presumption that they are caused by fear of death and injury. There is little evidence that fear of death is the cause of such casualties. More important variables that increase the soldier’s symptom formation are the fears of letting others down or not being able to meet the expectations of combat (Grossman, 2009), along with the toll of autonomic nervous system responses to constant hypervigilance (Porges, 2009, 2011).

Many soldiers face the loss of a comrade, which is emotionally devastating and often leads to prolonged, unresolved grief, mourning, and anger. Survivor guilt is often intense, and veterans who blame themselves for the death of a comrade, due to their own inaction or erroneous action, are potentially at higher risk for psychological or psychiatric casualty, including increased risk of suicide (NCPTSD & WRAMC, 2004).

Treatment considerations for veterans are driven by the symptoms that are displayed and revealed through extensive assessment. The whole person is affected by traumatic events, and, as a result, the individual experiences PCEBS symptoms (physical, cognitive, emotional, behavioral, and spiritual). The symptoms displayed by returning veterans are detailed later, in the section entitled Counseling Implications.

Review of the primary treatment modalities that have extensive research bases include trauma-focused individual cognitive behavioral therapy, interpersonal group therapy, peer-support groups, family and couples counseling, pharmacological approaches, primary medical care, and integrated treatment for co-occurring mental illness and substance abuse (Department of Defense Task Force on Mental Health, 2007; Matsakis, 1994; President’s New Freedom Commission on Mental Health, 2003). A recent U.S. Department of Veterans Affairs (2020) publication has identified the following trauma-focused psychotherapies as having the strongest evidence for use with veterans: prolonged exposure (PE), cognitive processing therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). This publication recommends other types of trauma-focused psychotherapy that also may be indicated for people with PTSD, including brief eclectic psychotherapy (BEP), narrative exposure therapy (NET), written narrative exposure, and specific cognitive behavioral therapies (CBTs) for veterans with PTSD.

There are emerging best practices and innovative therapies that are showing significant benefit for individuals with PTSD. The Veterans Health Administration has widely disseminated two empirically supported treatments for PTSD: CPT and PE (Karlin & Cross, 2014). According to Holder et al. (2020), veterans with certain comorbidities and clinical complexities (e.g., MST) were more likely to initiate treatment with CPT or PE, but those with certain comorbidities (e.g., pain disorder or depressive disorder) were more likely to have a delay in treatment of trauma.

Bodywork therapies have been explored, such as acupuncture, acupressure, and healing touch. Animal therapies such as equine therapy and pet therapy (e.g., psychiatric service dogs) are showing promise in helping PTSD clients to expand their social interaction and emotional healing. Expressive therapies allow clients to use various forms of nonverbal communication to express themselves creatively and to aid in recovery. Art therapy, sand tray therapy, music therapy, and drumming are just a few of these expressive therapies. Lifestyle

therapy, music therapy, and drumming are just a few of these expressive therapies. Lifestyle and nature therapy techniques such as healthy lifestyle counseling, nutritional awareness, recreational activities, and connecting with nature and spiritual well-being are additional techniques used to augment traditional therapeutic interventions. Physical therapy and exercise that promotes overall wellness helps to realign mind, body, and spirit through activities such as yoga, physical therapy, personal training, soft-style martial arts like Tai-Chi, dance, and other movement therapies. Relaxation and stress reduction techniques also are useful and include biofeedback, guided imagery or visualization, and massage therapy.

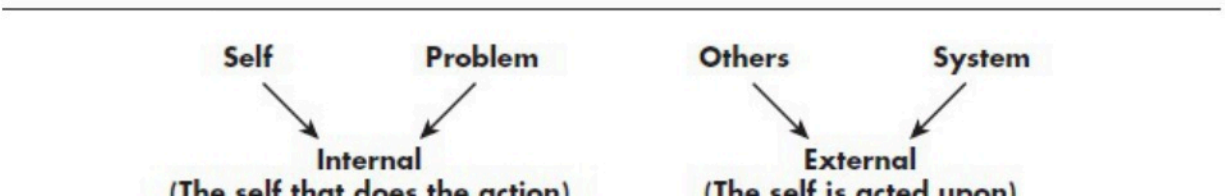
Cranial electrotherapy stimulation (CES) is being prescribed more and more for both service members and veterans for the treatment of PTSD, depression, anxiety, insomnia, and chronic pain. Multiple studies (e.g., [Hare et al., 2016](#); [Kirsch et al., 2014](#); [Platoni et al., 2019](#)) have reported highly significant decreases in symptoms of the previously noted diagnoses. CES has been prescribed by the Department of Defense and the Veterans Affairs since the early 2000s; however, it was not until more recently that the utilization of CES to treat these conditions increased significantly. Electromedical Products International, Inc. (EPIi) has seen an increase from 2,791 devices delivered to service members or veterans in 2011 to 13,859 devices delivered in 2019 (Laura Alcaraz, EPIi sales representative, personal communication, June 18, 2020). This increase in CES utilization was likely the result of the Kirsch et al. study in 2014 that was based on just over 1,500 service members and veterans. CES was compared to several of the more common drugs used to treat depression, anxiety, PTSD, insomnia, and pain and was proven to be as effective or more effective than the medications without the side effects of the drugs ([Kirsch et al., 2014](#)). CES is a very effective tool that is safe to use and comes without the side effects of medications.

There are several medications approved by the Food and Drug Administration (FDA) for the treatment of PTSD. Traditional selective serotonin reuptake inhibitor (SSRI) medications such as Zoloft and Paxil have been widely used for years, but Ketamine was approved in 2019 for the treatment of treatment-resistant depression as well as PTSD. Ketamine acts like an antagonist to the NMDA receptor, a glutamate receptor and a major excitatory neurotransmitter in the brain that plays a large roll in PTSD.

Recovery

Early trauma research focused on two basic areas in an attempt to explain problematic psychological symptoms after exposure to traumatic events. First was the literature suggesting that people who developed problematic psychological symptoms had a predisposition or susceptibility to psychological breakdown ([Ettegui & Bridges, 1985](#); [Worthington, 1977](#)). Second was the opposing literature that focused on the analysis of the traumatic event as the appropriate predictor of problematic human response ([Boulanger, 1986](#); [Foy et al., 1987](#)). [Figure 25.1](#) illustrates how these opposing views align with the more holistic views of [Buck \(1998, 2012\)](#), [Cohen \(1993\)](#), and [Webb \(1991\)](#), who suggested that there are important personal traits and characteristics of the event that determine individual responses to traumatic events. The whole person is affected by traumatic experiences, and this interaction consists of internal and external variables. The internal variables include personal characteristics and the circumstances of the trauma. The external variables include personal support systems (e.g., family, friends, peers, school, and churches) and professional support and treatment services.

Figure 25.1
Four Central Dimensions of Recovery



(The self that does the action)

"Self"

Is based on:

- Beliefs
- Fears
- Identity—Who I am in this world
- Health
- Attitude—Positive or negative
- Knowledge—Self recognizes about world
- Meaning—Way self interprets world

(The self is acted upon)

"Others"

Significant people & events:

- Family
- Peers
- Clinicians
- Larger society

"Problem"

- The (what happened) or the thing that the person must recover from
- From the problem we derive:
 - A. Cause
 - B. Effect
 - C. Possible solutions

"System"

Primarily the Mental Health System:

- Diagnosis
- Medications
- Facilities/Programs
- Professionals
- Disincentives

Other systems that affect recovery:

- Educational
- Legal/Penal
- Human services
- Larger society

Variables for Recovery, Resiliency, and Reintegration

Recovery, resiliency, and reintegration are the three essential aspects of the military veteran's life-adjustment process that need to be considered by clinicians and students of military trauma. These three aspects are detailed in the following text.

Recovery Variables

Explaining the recovery process is perhaps best understood by identifying what an individual is attempting to recover. [Buck \(2012\)](#) proposed that the traumatized military veteran is trying to reestablish the following seven characteristics:

- 1.Recover a sense of personal "competency."
- 2.Recover a sense of personal "autonomy" (understand the "self" and how to relate to the world as a result of the changes to self).
- 3.Understand the impact of the objective traumatic experience as well as the subjective responses and symptom formation.
- 4.Recover a sense of intimacy and trust, enough to be vulnerable and flexible in intimate relationships with significant others.
- 5."Trust" self and one's capacity for building trusting relationships with peers, coworkers, and society in general.
- 6.Develop a deep understanding about the trauma and the subjective interpretations about the meaning the experience has had on a sense of connection to the outside world.
- 7.Recover a positive personal identity, personality, and self-image, recognizing how each has been affected by traumatic events.

Resiliency Variables

Human beings are adaptable and have various innate strengths that can carry them through adversity and dangerous experiences. Like recovery, resiliency is best defined through the various indicators that demonstrate success in adjustment. The Army National Guard ([ARNG, 2010](#))

2010) has developed a leader's guide for assessing and ensuring support for soldier resilience (*ARNG Leader's Guide: Soldier Resilience*). This guide provides extensive information on how to build resilience in the individual, the military unit, and the family during deployment. The following 12 indicators of resiliency are a comprehensive listing of concepts included in the *ARNG Leader's Guide* and have been skillfully compiled and summarized by the [Ohio Department of Mental Health \(2008\)](#) in their *Youth and Family Consensus Statement on Resiliency and Children's Mental Health*:

1. **Validation and valuing:** Appreciate life circumstances and life realities experienced
2. **Safety and basic needs:** Recognize and meet personal needs through personal strength and seeking supports as needed
3. **Sanctuary:** Identify a personal and protected space
4. **Justice:** Recognize that one has personal rights, voice, respect, and dignity. One needs to fight stigma and stereotype while making a commitment to self and others
5. **Competencies:** Recognize one's unique strengths, skills, talents, and abilities
6. **Self-wisdom:** As in recovery, recognize self as expert in one's own experiences and develop practical knowledge about coping/managing behavioral/emotional challenges
7. **Courage and confidence:** Personal courage and bravery to deal with life stressors
8. **Supportive connections:** Resiliency is nurtured by family, friends, peers, and professionals
9. **Expectations:** Maintain expectations that are reasonable and achievable and that maximize functioning and potential
10. **Participation:** People thrive when given opportunities to contribute, participate, and maintain positive involvement
11. **Hope and optimism:** Opportunities that challenge emotions often result in development of hope for a positive future
12. **Sense of meaning and joy:** Seek and find happiness, meaning, and joy in life events that bring satisfaction and quality to life

Reintegration Variables

Military veterans experience extensive training and preparation for the events that occur during time of war and in combat situations. During deployments and training exercises, military individuals are transformed into an elite fighting force whose mission is to overpower and destroy enemy forces. Changes have occurred within the veteran and in the family that must be assimilated. Being prepared for these changes is an important process, just as preparation for war is an important process. Military veterans with extensive traumatic experiences may have a more difficult time adjusting due to symptom formation. All military veterans potentially experience some need for reintegration training.

COUNSELING IMPLICATIONS

It is important for counselors and supportive others to recognize the PCEBS symptoms (physical, cognitive, emotional, behavioral, and spiritual) that manifest following traumatic events. Veterans and their families must realize that they may observe the veteran pacing, acting impulsively, walking aimlessly, distrusting others, being jumpy or startled by loud noises, spacing out, or having erratic movements that they did not have previous to deployment. It also is extremely important for veterans and their significant supporters to notice if there is an increased use of alcohol or drugs as a way of self-medicating for some of these symptoms.

How the veterans *feel*, both physically and emotionally, determines their success at reintegrating into family, work, college, or other civilian environments. Physical feelings such as muscle tension and pain, dizziness, headaches, grinding of teeth, stomach upset, chest pains, incessant thirst, fatigue, or fainting may all impact adjustment. Emotional feelings also will influence this adjustment process. Mood disturbances such as fear, panic, emptiness, sleep disturbance, uncertainty, anger/hostility, blame, grief, guilt, high anxiety, or flashback experiences all may be present within the combat veteran. Cognitive distortion such as intrusive thoughts, memory and concentration difficulties, recurring nightmares, confusion,

intrusive thoughts, memory and concentration difficulties, recurring nightmares, confusion, preoccupation, self-blame, and distorted body image may interrupt the recovery process. These symptoms potentially cause relationship strain as well as personal isolation and withdrawal by the veteran. Many veterans report an extreme desire to connect intimately with others, but they often are reluctant because of lack of trust in self and others.

Trauma-Related Triggers

Triggers are usually external environmental sensory data such as sights, smells, sounds, tastes, or touch that stimulate an internal response. The internal response is usually an increased negative symptom, as listed previously, and is uncomfortable or disturbing for the individual. This sense of negativity is potentially interpreted subjectively as an indication that the person is “damaged” or “diminished” in some way because of the inability to control that reaction (Buck, 1998, 2012). Some typical triggers for combat veterans include the anniversary of the traumatic event, smells, loud noises, excessive stress, extreme guilt, feeling left out, work or school stress, relationship breakup, traffic, financial problems, being overly tired, sexual harassment, hearing others argue, being judged or criticized, spending too much time alone, and intimacy.

Making sense out of senseless life experiences is a truly monumental task for war zone veterans who have witnessed atrocity and loss of life of a comrade. A “crisis of faith” (Herman, 1992) may develop that potentially disrupts a trauma survivor’s ability to create any positive meaning in life. Some of the *spiritual* responses experienced by many veterans include having anger at God; stopping attendance at religious services; experiencing emptiness or meaninglessness; feeling God has failed; questioning basic beliefs about self, the world, and God; and being angry or cynical toward clergy. Counseling professionals who are trauma-informed understand that these are “normal” responses to “abnormal” wartime events.

Healing Through Meaning

Ultimately, recovery from military and war zone traumatic events is an individual, personal, and private process that a soldier/veteran experiences. Veterans may not fully share themselves with others who do not understand the sensory reality of war. For many veterans, there is a lack of trust, a sense of personal damage, and alienation from others. Veterans typically desire to regain the capacity to connect intimately with others; however, their PCEBS symptoms interrupt their ability to do so. To “recover” from traumatic events, some veterans find meaning or make sense out of their war trauma through personal accounts of their experience. Telling their stories can provide significant cathartic relief for many veterans. Numerous examples of these narratives exist in the literature (e.g., Hedges, 2002; Kraft, 2007; Tick, 2005, 2014). Finding positive meaning in the face of traumatic events is a first step in the recovery process. Frankl (1955, 1963, 1978) warns that personal meaning derived through suffering must take place only when suffering is inescapable or unavoidable. Combat veterans experienced an environment in which suffering was unavoidable. It is essential that those who are recovering from traumatic events create a positive subjective interpretation and understanding of those traumatic life experiences. Through resiliency, as outlined previously in this chapter, military veterans may find positive meaning in their suffering. Trauma victims who are able to make sense of their experience and understand their reactions/symptoms are in the process of recovery (Buck, 1998, 2012; van der Kolk, 1984, 2014).

CONCLUSION

This chapter has examined a complex anatomy of war trauma and the unique issues, problems, and challenges that military veterans must address in their recovery process. Personal characteristics of the individual, specific variables related to the trauma event, and the availability of social supports interact to determine the degree of adjustment success

the availability of social supports interact to determine the degree of adjustment success following wartime experiences. Professionals who provide counseling services and other supports for military veterans must ensure that a comprehensive and accurate assessment of the various issues, problems, and challenges is conducted; at the same time, professionals must work toward a holistic understanding of the individual, as well as assuring that the individual's recovery and reintegration needs are met.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

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