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Combat-related posttraumatic stress disorder (PTSD) is a condition that shows stress symptoms after trauma exposure in a warzone (Fragedakis & Toriello, 2014). Termed as “battle fatigue”, “combat fatigue syndrome”, “warzone stress”, and “shell shock” through World Wars I and II and the Korean War, PTSD was noted among soldiers who experienced a collapse of mental and physical resources after battling in war (Nolen-Hoeksema, 2014).

An exposure to a traumatic event, characterized by actual or threatened death, serious injury, or sexual violence, is criterion A (i.e., index trauma) of PTSD (American Psychiatric Association [AP

Bliese, & Moore, 2013). Increased PTSD symptoms are reported among combat soldiers who had elevated rates of combat exposure and multiple and longer deployments to Vietnam, the Persian Gulf, Iraq, and Afghanistan (Xue et al., 2016).

Posttraumatic stress disorder is considered one of the most common diagnoses in the military population (Xenakis, 2014). Many soldiers had PTSD diagnoses, of which rates doubled by 10-fold increase after they had experienced predeployment stressors. Around 18,305 U.S. soldiers attested that they had experienced having chronic PTSD within three to 12 months of active combat operations in Iraq or even decades after war (Nolen-Hoeksema, 2014). In the Philippines, Ilagan (2010) found out in her assessment of combat stress load of the 10th Infantry Division (10ID) that around one out of every four soldiers had high levels of combat-related stress. Ilagan posited that 10ID, the most engaged division of the Philippine Army, among PTSD w.5Ts of j 0.13dwere also

see various stressors in wa Thus, more than the risk of being wounded in

through one lens alone, but through different lenses that reveal an understanding of the phenomenon's multiple facets (Baxter & Jack, 2008). A detailed investigation of processes, then, can lead to processes that can be general or unique to a context (Yin, 2003).

Participants

Participants included three Filipino male active duty soldiers ranging in age from 28 to 45 diagnosed with PTSD. Two were confined at the psychiatry ward of the Armed Forces of the Philippines Medical Center (AFPMC) and one at the heroes ward of AFPMC. Participants were required to be aged 18 or over, to have sufficient proficiency in English and Filipino to complete psychological tests and interviews, to have multiple PTEs prior to index trauma, and to have combat-related PTSD diagnosis. They were the only ones who met the inclusion criteria at the time of data gathering. Exclusion criteria were: having comorbid disorders, brain injury, psychosis that will disallow participation in interviews or psychological tests.

Procedures

The study was approved by the Ethics Review Committee of AFPMC. Participants, their significant others, attending nurses, and the resident psychiatrist provided their written informed consent to participate in the study. Data gathering started with an interview schedule, followed by the psychological tests and clinician-administered interviews. Each interview lasted from 1 to 1.5 hours and ensued whenever the client felt comfortable to do so. They were recorded on a digital audio recorder, transcribed verbatim, and translated into English.

Measures

To allow data triangulation, several measures were used in investigating specific phenomena. To validate and investigate the combat-related PTSD diagnoses of the participants, the following measures were utilized: interviews with participants and their significant others, attending nurses, and psychiatrist; Clinician-Administered PTSD Scale (CAPS-5); Trauma Symptom Inventory (TSI); Harvard Trauma Questionnaire (HTQ); and archival records.

3569. It has sensitivity between 92–96% and specificity of 91%. It has the ability to detect PTSD, because of the TSI scales' diagnostic utility of 86% (Briere, 1995).

Harvard Trauma Questionnaire (HTQ). Risk factors for PTEs or specifically directly/indirectly experienced traumatic events, index trauma, and PTSD were investigated using HTQ (HTQ; Mollica et al., 1992a). A self-report scale, HTQ measures traumatic and torture events and PTSD symptoms among individuals affected by torture, trauma, and war-related violence on a cross-cultural approach. It has good reliability of .96 for the symptom portion and a test–retest correlation of .92, with a 1–122 k interval between tests. It has good criterion validity with PTSD group (

strengthen data quality; (c) The researcher established rapport with the participants; and (d) Member checking, wherein participants were asked if the findings of the study hold true for them were done.

RESULTS

Findings show the participants' socio demographic profiles and military background in Table 1. Findings also validate that the participants really have combat-related PTSD, through the quantitative measures of CAPS-5, TSI, and HTQ (see Table 2); qualitative inquiries from interviews with participants and their significant others, attending nurses, and psychiatrist; CAPS-5; and archival records. Pseudonyms were used to protect the

Table 1. Sociodemographic Profiles and Military Background of Participants

	Jose	Manuel	Enrico
L u z o n w i t h P a l e n w i t h (1 . F g e n o u s w i t h			
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Table 2. Participants' Clinically Scores in PTSD Assessments.

	Jose	Manuel	Enrico
CAPS-5			
Criterion A = combat-related	Yes	Yes	Yes
B S ev	17	19	18
#B S x	5	5	5
C S ev	8	5	6
#C S x	2	2	2
D S ev	24	12	16
#D S x	6	3	5
E S ev	19	13	13
#E S x	6	4	4
Total S ev	68	49	53
Tottal S x	19	14	16
Duration of disturbance	>1 month	>1 month	>1 momth
G S ev	12	9	10
#G Sx	3	3	3
TSI			
Anxious arousal	72	74	80
Depression		82	
Anger/irritability		75	
Intrusive experiences	73	84	73
Defensive avoidance	71	70	
Diassociation		78	
Sexual concerns		72	
Dysfunctional sexual behavior		68	
Impaired self-reference	66	79	
Tension reduction behavior		72	
HTQ	3	3.47	2.53

Note. B = Criterion B; C = Criterion C; D = Criterion D; E = Criterion E; G = subjective distress, impairment in social functioning, and impairment in occupational functioning; Sev = Severity; Sx = Symptoms.

participants' identities. The PTE risk factors were also unfolded from the qualitative inquiries from interviews with participants and their significant others, attending nurses, and psychiatrist; LEC-5; HTQ; and archival records. The categories of PTE risk factors are presented below.

The PTE risk factors for combat-related PTSD were categorized into three: combat-related experiences, precombat and postcombat experiences at work, and nonmilitary experiences. They were all prior exposures to trauma before the soldiers' index traumas occurred. Each PTE risk factor is marked by either actual or threatened death to oneself or to others, physical injury, sexual violence, or a threat against physical integrity. It also resulted

Like Jose, Manuel witnessed his comrades being killed. He recounted, “During our encounter with the ASG, I saw how my comrade beside me was killed. Large bullets fell on him, crushing his face…leaving him dead on the spot…I was shocked. At another encounter, my troops were captured by the ASG. They were killed by the NPA.”

Enrico also relayed his comrades’ deaths, which he closely witnessed. He stated, “I saw the death of our commander…I was shocked…I saw how his body was crushed by the mortar fired by the ASG.”

Enrico expressed his dismay when he shared, “I witnessed six Scout Rangers being beheaded by the ASG.”

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motorcycle accident…my wife no longer wanted me to ride a motorcycle for fear I might die."

Besides experiencing sexual harassment, a physical attack, and a motor vehicle accident, Jose also shared his frustrations regarding family disruption and financial strains. He recounted, "My parents separated…I wanted them to be back together…It was so saddening that even after so many years it still never happened…I also remember that we had financial problems that my mother had to transfer me to another school."

Manuel also had the same feeling when it comes to his family. But it was about his father's death. He expressed, "It was untimely when my father died. I despaired over it…I had just successfully entered the military that time…I couldn't believe it…I could no longer show to him that I was already a soldier."

Manuel was just on his first year of service in the AFP when his father died. He felt that he could have shown to his father all his achievements had he not died that early. Manuel also recounted their family's experience of losing their home through a natural disaster. He narrated, "The Mt. Pinatubo eruption destroyed our house in 1991…we did not have anything to eat…our farm where we used to get our food and means of living was wiped away by hot lahar…life was so difficult…we had nothing to eat…I had to stop high school…it took two years before we were able to recover from the ruins and losses the disaster had brought us."

Enrico also had his share about the death of his father. Enrico disclosed, "My father suffered from stroke for 11 years…It was difficult for me to see him suffer that way."

Enrico's brother also died. He blamed himself for what had happened. He revealed, "My brother died…he was murdered…I felt it was my fault…it so happened that we had different gangs when we were adolescents…My gang accidentally killed him…it was too late when I found out that he was there during that riot….I felt guilty about it."

Enrico's home and means of living were also destroyed, but unlike Manuel, it was the rebels who destroyed all of their properties. He recounted, "Our house…our farm…our business… they were all destroyed by the NPA. It led to financial problems."

Enrico also shared some domestic disruptions. He expressed, “I was so young when I had a live-in partner…I was still immature…everyday my wife and I fought…it was chaotic and stressful…my life had no direction and I was irresponsible…I used to smoke and drink…My wife used to gamble.”

DISCUSSION

The purpose of this study was to investigate on the PTE risk factors for combat-related PTSD. For purposes of descriptive explanation, the sociodemographic profile and military background of each participant were also presented.

Two active combat soldiers with PTSD were in their late twenties and the third one was in his mid-forties. All of them are male. Research on veterans attests that people who are more symptomatic with PTSD are in their younger age (Naifeh, Del Ben, Richardson, & Elhai, 2010). In contrast to this, the study of Roberts and Browne (2011) on postwar settings confirmed that increasing age determines one having PTSD. With regard to gender, it was shown that anyone can be vulnerable to PTSD regardless of gender (Naifeh et al., 2010).

Each of the two participant-soldiers finished two years of college education, and the third one finished secondary education. Roberts and Browne, in their study on post conflict settings, contended that such socioeconomic factors are known to exist among trauma-exposed populations with poor psychological health.

Participants, who are all active duty soldiers, came from the Philippine Army branch of se5241yicend the thyd no dumend smbat solencgerminsn con Eacdy

and

The PTE risk factor for combat-related experiences led to the soldiers' low morale. It had been the duty of combat soldiers to fight for the country, to be tough, and never leave a fallen comrade behind. However, they are also subject to the effects of warzone stress exposures, especially when enemies penetrate their perimeters. James, Kampen, Miller, and Engdahl (2013) examined combat experiences as posing a deleterious impact to soldiers' mental health, such as them later having PTSD. The levels of combat exposure (l93a

like family deaths and separations, together with ongoing worry about the family. Jose also had prior trauma of sexual harassment. Polusny et al. demonstrated that prior interpersonal victimization and sexual stressors are associated with the risk of PTSD symptoms. A history of sexual assault or sexual trauma increases the risk of developing PTSD.

It is important to note the limitations of this study. First, quantitative measures were self-report ones, which may include bias. Second, the participants were all from the Philippine Army and have combat-related PTSD diagnosis. Findings may not be generalized to other branches of military service and to other types of PTSD. Third, data gathered through qualitative inquiry may have retrospective report bias. Fourth, the risk factors investigated focused only on PTEs.

Despite limitations, the study has its strengths. First, case study design was utilized to allow data triangulation and corroboration of evidence from multiple data sources. Second, findings give rich descriptions of the phenomena. Third, trustworthiness of the data was ensured. Fourth, the PTSD diagnosis of the participants ensures that the investigated risk factors are for combat-related PTSD. Fifth, quantitative endorsements of participants in psychological tests were validated through qualitative inquiries. Sixth, participants are all from the Philippine Army, the biggest branch of service in the AFP. Findings may apply to soldiers with similar experiences and settings.

Findings of the study supplement the risk factor literature for combat-related PTSD. The qualitative approach of the study presents an enriched understanding of the PTE risk factors as experienced by soldiers and how they are affected by these PTEs. These valuable data can guide the development of preventive interventions for combat soldiers, given that the wars between soldiers and terrorists and/or rebels have been prevalent nowadays.

At various points, protection for our soldiers from having PTSD may be provided. For example, before entering the military, they may be given psychological processing of their previous PTEs. Once in the military, they may be given psychological preparation before deployments. Then, psychological debriefings may be immediately provided after every combat encounter. It is useful to note from D. Grossman (personal communication, February 9, 2017) that the term “debriefing” was first used in the military in World War I, wherein pilots were given a “mission brief” before their mission

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