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Fields of Combat:
Understanding Post-Traumatic Stress Disorder among
Veterans of Iraq and Afghanistan

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An abstract of
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Abstract

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By Erin P. Finley

Post-Traumatic Stress Disorder (PTSD) has received increasing attention as one of the "signature wounds" of the U.S. wars in Iraq and Afghanistan, with more than 75,000 returning veterans newly diagnosed since 2002. Epidemiological and clinical accounts of the disorder have struggled to understand how social and cultural factors may influence veterans' vulnerability to developing PTSD after combat exposure, while anthropological explorations of PTSD have told us little about the personal experience of PTSD, tending to focus instead on a critique of the diagnosis' status as an authoritative biomedical category. The present study addressed these gaps by using both ethnographic and epidemiologic methods to investigate how recent male veterans and their families understand and respond to post-deployment stress and PTSD. Findings consider veterans' experiences of post-deployment stress in the context of key social and cultural variables such as Mexican-American and Euro-American ethnicity, family relations and masculine gender roles, and amid wider understandings of PTSD in clinical and media accounts of the disorder. Living with a diagnosis of PTSD turns out to require navigating multiple and often contradictory fields of social meaning simultaneously, with implications for how veterans make decisions vital to their experience of illness –

including coping strategies and efforts toward care-seeking and meaning-making. Retrospectively following veterans across a trajectory of cultural environments and life course events, this dissertation explores how social relations, political economy, and lay and professional notions of illness and gender help to shape veterans' vulnerability and resilience as they work to create post-war lives, often amid profound distress.

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This dissertation is dedicated to my mother.

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Preface

This dissertation is an ethnography of combat-related Post-Traumatic Stress Disorder (PTSD) among U.S. male veterans of Iraq and Afghanistan.[1]

Since shortly after the invasion of Iraq in 2003, America's most recent veterans have been at the center of a national conflict over the viability and wisdom of these wars. The problem of providing them with adequate health care has been a frequent topic of media attention, most dramatically in the maelstrom of public outrage that surrounded the 2007 Walter Reed scandal (when it was revealed that wounded soldiers receiving outpatient care at the nation's most prominent military hospital were living in crumbling former barracks buildings, toxic with mold). Veterans of Iraq and Afghanistan – buoyed by the support of older veterans who themselves carry forward a legacy of political neglect – continue to engage in a highly public battle with the Department of Veterans Affairs (VA) over its failure to provide appropriate health care and compensation for service-related disabilities. No less fraught, PTSD itself remains hotly debated among psychiatrists, psychologists, and others who disagree about what sort of illness it is, what causes it, and how best to treat it. During the course of the research for this dissertation, it became clear that these professional battles were in the process of revolutionizing how the VA provides trauma care to veterans, redefining the way PTSD illness is understood in the process. This dissertation will untangle each of these conflicts and reveal the

[1] The accepted spelling of post-traumatic stress disorder, posttraumatic stress disorder, and/or post traumatic stress disorder is so consistently inconsistent that I have chosen to go with the spelling I find most aesthetically pleasing.

very real implications they have for shaping the well-being of veterans and their families, now and for decades to come.

As an anthropologist, one of the reasons I find this web of tangled arguments over PTSD and veterans' rights so fascinating, besides the fact that these conflicts are in many ways about the nature of war-related suffering itself, is because they illustrate so clearly that point of interface where personal experience and cultural politics come together. The stories of struggling veterans trying to understand what has happened to their lives in the wake of their time in Iraq or Afghanistan, amidst the havoc that has been wrought on their families and sense of self, illuminate how suffering is embedded in the political, economic, and cultural circumstances that make up the context of everyday life.[2]

Reflecting this vantage-point, the dissertation interweaves two main focal points: veterans' personal experiences of PTSD, and the cultural politics that surround and shape those experiences. In Part I, I follow the chronology that most veterans themselves take – into the military, off to war, and returning home – in laying out how individual veterans described their time in the service and how they made sense of what began to go wrong in the months and years after their return home. Chapter One, "Gearing Up", lays the groundwork for the dissertation, detailing the study methods and describing how many of the veterans came to join the military. Chapter Two, "War Stories", explores the stories that veterans tell of their time in Iraq and/or Afghanistan, attending to how these stories are told and what they reveal about the nature of war trauma for these men. Chapter Three, "Home Again", describes what happened

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[2] This is a classic area of scholarship within medical anthropology, particularly within the literature on social suffering (e.g. Bourdieu & Accardo, 1999; Das, Kleinman, Lock, Ramphele, & Reynolds, 2001; Das, Kleinman, Ramphele, & Reynolds, 2000; Kleinman, 1986; Kleinman, Das, & Lock, 1997b) and critical phenomenology (e.g. Biehl, 2005; R. R. Desjarlais, 1997; B. J. Good, 1994).

when these veterans came home from war and first noted the phenomena that they would later come to call PTSD symptoms, before considering how these transformations may begin to affect veterans' social relations and placing them in the context of other life stresses and risk factors for PTSD.

Part II widens the analytic scope to explore how PTSD and post-deployment stress are understood in three complex cultural environments through which most PTSD-diagnosed veterans will pass: within families, the U.S. military, and the VA's mental health care system. Observing how PTSD is debated and managed in each of these environments makes it possible to appreciate the life challenges this illness can create for recent veterans, as well as the many messages around PTSD that are available to them. In Chapter Four, "Of Men and Messages," I consider how veterans and their families respond to the crises brought on by post-deployment stress, and explore how cultural ideas around illness and male gender shape veterans' coping and care-seeking behaviors. Chapter Five, "Under Pressure", describes how public uproar and media scandal have spurred the U.S. military to augment PTSD screening, prevention, and treatment programs in recent years, while also drawing out the social and structural pressures that help to perpetuate stigma in the military. Chapter Six, "Embattled", begins to examine the politicized world of VA bureaucracy and professional mental health care that veterans enter when they seek help at a San Antonio-area VA mental health clinic; Chapter Seven narrows in on therapeutic interactions in this setting by ethnographically exploring how veterans and clinicians negotiate the meanings of PTSD in group therapy sessions.

Part III returns to the focus on individual veterans, exploring how they traverse the challenges created by PTSD, responding to and drawing upon the accumulating layers of experience they have acquired in their encounters with family and within the realms of the

military and VA. Chapter Eight, “Ambivalence”, explores the contradictions inherent in American perspectives on veterans, generally viewed as both heroic and dangerous, and examines how this legacy shapes PTSD-diagnosed veterans’ efforts towards a positive identity and moral life. Chapter Nine, “Maps”, reveals how individual veterans have found ways to approach treatment and life afterwards, treading cautiously amid symbolic minefields in their efforts to move past PTSD. The final chapter concludes with a consideration of how PTSD is defined and debated in contemporary social science, offering a series of recommendations for treating and preventing PTSD among current and future veterans.

Along the way, this dissertation will address a series of questions:

- What do we know about the causes of PTSD? What social and cultural factors are implicated in its etiology? Why do some people develop PTSD while others do not?
- What is it like to live with combat PTSD? What is at stake for veterans living with a PTSD diagnosis?
- How do veterans and their family members understand PTSD, and how do these understandings shape care-seeking and coping behaviors? What cultural influences are at work here?
- What do clinical and institutional (e.g. VA and military) responses to veterans’ problems with homecoming look like? What influences appear to be driving these responses?
- And finally, how are these social, clinical, and institutional responses shaping the current and future well-being of veterans and their families?

In taking on these questions, this dissertation describes a collision of trajectories – veterans’ personal trajectories of self and life, the cultural and historical trajectory of war in the American imagination, and the trajectory of a dramatic professionalization occurring in trauma-

focused mental health care. In following each of these arcs and witnessing how they collide, I hope to show how such impacts reverberate, forcing each trajectory along a different path than might otherwise have been the case.

At the same time, this dissertation is also about the stories that get told of war and its aftermath, including: the kinds of war stories veterans tell (and don't tell) (Chapter 2); the kinds of stories families tell about their experiences of PTSD (Chapters 3-4); the stories the military tells about combat and its effect on service members (Chapter 5); the stories the VA tells about its responsibility to veterans (Chapter 6); the active debate over what kinds of trauma stories may heal veterans, and what kinds of stories may be dangerous (Chapter 6); the legacy of stories told of earlier wars and earlier veterans (Chapter 8); and the combined power of all these personal and cultural stories in shaping how modern-day veterans cope with their own experiences of war and trauma (Chapter 9).[3]

Assembled together, these many stories shed light on the ambivalent relationship that America has with its veterans, who are both idolized and feared, and with PTSD, which turns out to stand for – not only the personal aftermath of a nation at war – but all the ways in which veterans' suffering is named, claimed, and made sense of in modern America.

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[3] Jerome Bruner has written that: "To be in a viable culture is to be bound in a set of connecting stories, connecting even though the stories may not represent a consensus." (1990: pg 96)

Part I - The Journey Begins

Personal Histories of Service and Stress

Gearing Up

A Tradition of Service in San Antonio

Chapter One

July 4th, 2007, dawned rainy in San Antonio, but the sky was clearing by early afternoon. The sun came out and the day turned sweltering just about the time I found a seat at an empty picnic table down at the local Veterans of Foreign Wars (VFW) Post. An older woman in a red shirt came and joined me at the same table, sheltering under the shade of the umbrella. She introduced herself as Melissa, and we chatted for a while, laughing about the fact that we had both gotten lost on the way to the VFW.

We were both there for the same reason. As part of its Fourth of July celebration, the VFW was dedicating a new memorial to 53 young men and women from San Antonio who had been killed in the "Global War on Terror," then more than five years in the making. After six months of working with veterans of Iraq and Afghanistan out of the local Department of Veterans' Affairs (VA) hospital, I wanted to see the ceremony, and to pay my respects.

I had moved to San Antonio earlier that year, intending to study the psychological consequences of the ongoing wars for the veterans who had been sent to fight them, those who are referred to in military and VA circles as veterans of Operation Enduring Freedom (OEF; Afghanistan) and Operation Iraqi Freedom (OIF; Iraq). Since September 11th, 2001, when

hijackers took over four commercial planes and used them to launch attacks on the World Trade Center in New York and the Pentagon in Washington, D.C., the U.S. has deployed more than 1.6 million U.S. military service members overseas. Upwards of four thousand American personnel have been killed, alongside hundreds of thousands of Afghans and Iraqis.[1] In excess of 30,000 Americans have been wounded in action, but more than twice that many – some 75,000 men and women – have returned home to be diagnosed with the most common and least visible of wounds: the psychological injury of PTSD.[2]

PTSD is the technical name for a complex of symptoms that arise in the wake of a traumatic experience that causes feelings of "fear, helplessness, or horror".[3] News reports on PTSD in the American media have made a habit of describing many of these symptoms: an overactive startle reflex, a sense of always being "amped up" and on edge, short temper, a sense of alienation and distance from loved ones, an intense desire to avoid reminders of war-related memories, and the uncontrolled invasion of these memories into veterans' waking and sleeping life.

As an anthropologist who has studied the effects of violence on mental health among former combatants in Northern Ireland, heroin and cocaine users in Boston, and Sudanese refugees living in Atlanta, I was moved by such media reports and their tales of the escalating numbers of men and women returning from combat to find their lives and selves in turmoil. I

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[1] (Burnham, Lafta, Doocy, & Roberts, 2006; *Operation Iraqi Freedom U.S. Casualty Status (October 1, 2008)*, 2008)
[2] (*Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans.*, 2008)
[3] (Yehuda, 2002a: 108)

found myself asking, what does PTSD mean for veterans of Iraq and Afghanistan, and what impact is it having on their lives and their families? What is it like to live with combat PTSD?[4]

I set out to answer this question by climbing into my car – a woman anthropologist, white, agnostic, Yankee, and politically liberal – and driving a thousand miles across the Red State/Blue State divide to San Antonio, Texas. There I settled in to work for a year and a half among a group of PTSD-diagnosed veterans – multiethnic, mostly male, often religious, generally conservative, and largely from the Southern and Midwestern U.S. I chose San Antonio because it has one of the largest populations of retired service members in the nation, as well as two Air Force bases, an Army base that is home to Brooke Army Medical Center, where many of the wars' wounded are being treated, and a heavily utilized VA healthcare system.[5] Across a table in a little room within that VA, some 60 veterans and I began a long and ongoing conversation about war, trauma, and PTSD.

It was with the faces of these men and women in mind that I ended up at the VFW that Fourth of July, remembering their tales of growing up in towns and cities like San Antonio, of being raised on stories about the noble service of veterans past and present. The events that afternoon seemed to hint at something of what I had come to San Antonio seeking to understand – how war and its aftermath becomes part of daily life for veterans and their

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[4] This question reflects the experience-near approach of phenomenological anthropology, which I have relied upon heavily in conceptualizing the ideas developed here (e.g. Csordas, 2002; Jackson, 1998; Kleinman & Seeman, 2000a). Given that combat PTSD in this current context results directly from state-level violence, my viewpoint is also unabashedly critical in its attempt to bring together historical, political economic, and interpretive perspectives (R. R. Desjarlais, 1997; B. J. Good, 1994). This analysis also owes considerable debt to the anthropologies of violence and suffering more generally (Dickson-Gomez, 2003; Feldman, 1991; Hinton, Pich, Chhean, & Pollack, 2005; Kleinman, Das, & Lock, 1997b; Nordstrom, 1997; Robben & Suarez-Orozco, 2000; Scheper-Hughes, 1992).

[5] (NEPEC, 2009)

families, and how generations of American warriors have embarked upon military service, only to find themselves face to face with unexpected consequences.

In the end, although I came to San Antonio with a complex set of questions about PTSD and veterans, I came to realize that the most essential lesson about PTSD is a relatively simple one – namely, that it is impossible to understand PTSD without an appreciation for the disorder as both an individual's experience of illness and a hotly contested social product, deeply rooted in American politics, history, and culture. The problem that many male veterans of Iraq and Afghanistan have in living with combat PTSD is a problem of navigating the challenges of the illness itself – its symptoms and suffering – while simultaneously struggling to make sense of a swarm of circulating ideas about what means to have PTSD, what it means to be a man, and what it means to be a combat veteran. It is in the effort to build an acceptable life amidst this whirlwind that PTSD-diagnosed veterans get lost or find their way. This dissertation is about that whirlwind, and about the ways that veterans find to make their way through it.

Setting the Stage

Because San Antonio has a high concentration of veterans and active duty military personnel, boys here often grow into young men amidst family legacies of military service and community pomp and circumstance honoring veterans. For the working and lower-middle classes in particular, military service offers not only a highly respected and high-adrenaline way to serve one's country, but also one of the better options available for getting an education and establishing a career.

Attempting to better understand the lives of these men and their families, I spent eighteen months in San Antonio, conducting ethnographic research among primarily Mexican-

American and Anglo-American veterans, most of whom had been diagnosed with combat-related PTSD. A local VA clinic that specializes in providing PTSD treatment generously offered support for the project and became home base for the work that followed.[6] Over the course of the research, which came to be known as the Post-Deployment Stress (PDS) study, I observed PTSD group therapy sessions and interviewed dozens of VA and community-based psychiatrists, psychologists, social workers, and local Veterans' Service representatives, all of whom brought with them their own perspectives on veterans and PTSD. These participants helped to illuminate how even the experts in mental health continue to debate over PTSD: its symptoms, its causes, and - perhaps most importantly - the best ways to encourage healing and recovery.

I conducted in-depth interviews with 62 veterans who represent a wide range of backgrounds and experiences: veterans of Vietnam as well as Iraq and Afghanistan; men and women; those who have been visibly injured or invisibly injured and those who are by all accounts whole and sound; representatives of the Army, Navy, Air Force, and Marines; and those who served on active duty as well as in the National Guard and Reserves.[7] In these

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[6] As with all studies, there was a prolonged series of steps required to make this research possible. A research proposal was written, complete with hypotheses and a structured study design. Funding was obtained from the National Science Foundation and the Emory Center for Myth and Ritual in American Life (MARIAL), and the study protocol was reviewed and approved by two Institutional Review Boards and five committees representing VA, employee, and other stakeholders. From the time I made initial contact with the clinic, it was a process of nearly two years before it was possible to begin the study in earnest.

[7] Veterans entered the PDS study through one of three routes. The first route was through clinician referral. A number of VA mental health and primary care clinicians provided information about the study to patients they thought might be interested; these patients then had the option of contacting me directly to request further information. The second means was through recruitment in VA therapy groups. When invited by VA clinicians, I would briefly visit the group, make a five-minute announcement about the study and leave behind a sign-up sheet for anyone interested. When the clinicians then passed the sign-up sheet along to me, I would contact those who left their information and provide additional information about the study. The third method was through recruitment flyers that were hung at the VA and several affiliated clinics in the San Antonio area, and also at local colleges and universities. Interested veterans

interviews – which were usually long and free-ranging, although we kept roughly to a list of open-ended questions – we talked about adolescence and growing up, about military service and combat in Iraq and Afghanistan, family life, experiences with PTSD and other injuries of war, goals for the future, encounters with military and VA healthcare systems, and the challenges of building a good life after leaving the military. These interviews were accompanied by extensive questionnaires collecting information on risk factors for PTSD, such as pre-deployment and post-deployment trauma exposure and social support. Other measures included scales assessing physical and mental disability and the severity of PTSD, depression, and anxiety symptoms.[8]

It turns out that the greatest challenge for many returning veterans is not just dealing with PTSD, but instead trying to manage their suffering while striving for a normative life in American society. As is the case throughout the world, trying to create a 'successful' life in the U.S. is a heavily gendered task. Although the current conflicts are remarkable for the growing and important role played by women serving in combat zones, I focus here on male veterans because being a man in America often means being "manly" in a way that may not be conducive to coping well with PTSD.[9] Often the ideals for men's behavior preclude expressing emotion or

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then contacted me directly and we discussed the study and their eligibility or interest by phone or email. Group announcements and recruitment flyers were the most frequently reported means of entry into the study. Family members were recruited either via participating veterans or by recruitment flyers. Clinicians and community members were identified via purposive and convenience sampling and contacted directly by me.

[8] Measures included 7 sections of the Deployment Risk and Resilience Inventory (DRRI) (D. W. King, King, & Vogt, 2003); the Post-Traumatic Checklist – Military Version (PCL-M)(Gray, Bolton, & Litz, 2004; Magruder, et al., 2004); the World Health Organization Disability Assessment Scale, Version II (WHODAS-II), which has been utilized previously to establish levels of disability among mentally ill populations (Alonso, et al., 2004); the 25-item Hopkins Symptom Checklist (HSCL-25), which is a commonly used measure of depression and anxiety among traumatized populations (Carlsson, Mortensen, & Kastrup, 2005; Sabin, Cardoza, Nackerud, Kaiser, & Varese, 2003); and the Brief Acculturation Rating Scale for Mexican Americans, Version II (ARSMA-II) (Cuéllar, Arnold, & Maldonado, 1995).

[9] (M. C. Gutmann, 1997; Sabo & Gordon, 1995)

accepting the sense of vulnerability that accompanies illness and suffering, and so men may be less likely than women to seek out the healthcare and social support they need to effectively manage such distress. Highlighting the experiences of men admittedly leaves us with a fairly traditional portrait of veterans and their families, of men going off to war and women marshalling the response at home, a portrait that does not represent many of the changes ongoing in how men and women engage in war on modern battlefields.[10] Five female veterans who had served in Iraq and Afghanistan participated in this study, and working with them was a lesson in how extraordinary such women are, and how unique their needs may be. I am grateful to the many researchers who are working even as I write to fill in the gaps in our understanding of female service members' experiences of combat stress, for this will be an important element of treating PTSD among veterans in the decades to come, as more and more women take on combat roles in the military.

Nevertheless, in exploring how male veterans of Iraq and Afghanistan spoke of their own emotions and experiences, I sought to better understand how these veterans make sense of their own suffering in relation to gendered American ideals of how men should behave *as men*. During the early days of the study, I asked veterans to talk about their life priorities and expectations of themselves, and used these responses to develop a ranking measure that was completed by later participants, providing insight into the concerns and values they held to be of greatest importance. Both questionnaire and interview data will be called upon throughout the dissertation to shed light on these questions.

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[10] Unfortunately, this portrayal also leaves out the experiences of men whose partners are men. Although one man who identified as gay did participate in the study, his concern for privacy was such that he did not feel comfortable addressing how he felt PTSD had affected his relationship with his partner.

Although veterans are at the heart of this dissertation, many other people and events are essential to the stories told here. One of the great joys of being an anthropologist is working in a field that values the social settings of ordinary life, and so I was able to go beyond the clinic and meet veterans' wives, girlfriends, and occasionally other family members for long discussions of their experiences with PTSD. They described how they often did not recognize their men after they came home from war, and how they made sense of their husbands' strange swings between anger, fear, grief, and withdrawal. We talked over coffee in Denny's and over chicken at Chick-Fil-A. We talked in their homes, where they could bring out pictures of "what he looked like before" and, once, could show me where he had punched a hole in the bedroom door. These women – for most were women – spoke of the way they understand PTSD and the challenges it creates for maintaining personal sanity and a cohesive family life. Their stories and strategies for coping say a great deal about how they view their husbands as men, and how they make meaning amidst the suffering that war has brought to their lives.

The freedom to move throughout the community also allowed me to learn from many of the other individuals and organizations who work locally with veterans and active-duty military, whether as veterans' advocates, Army chaplains (most of whom have served one or more tours in Iraq, providing spiritual support for soldiers in the combat zone), or as local artists and film-makers portraying the experience of veterans as part of local history. In all, some 133 veterans, family members, clinicians, and members of the community participated in at least one formal study interview.[11] Having access to life and research both inside and outside the

[11] Study participants (n=133) were divided into four groups: 62 veterans; 21 family members; 28 clinicians; and 22 community members. Although counted (and treated) as distinct study groups, the life roles

clinic made it possible to witness how PTSD is talked about and lived out across a range of settings, from the conversations between patients and therapists in group therapy to the "policy discussions" conducted at high volume during a local Veterans' Forum.

Understanding and Experience

What the sum total of these conversations, interviews, and observations makes clear is that PTSD means many different things to many different people. For veterans, it may be a profound alteration in the way that they experience themselves and the world. For family members, PTSD may be seen as an explanation (*Ah! That's why he's been acting this way!*) or an excuse (*He blames everything on his PTSD…*). For mental health clinicians working in this area, PTSD is a piece of specialized knowledge, a diagnosis on which they have a firm grasp, a natural occurrence whose course they hope to interrupt (although they may disagree vehemently with other clinicians on *how*). For many veterans' organizations and advocates, PTSD represents one shining fragment of the wrongs that veterans have been done by the military, by the VA system of healthcare and benefits, and/or by American society as a whole. All of these things can be said to be true.

All of these perspectives are also reflected in the individual veteran's experience of PTSD itself, affecting such questions as what symptoms a veteran comes to associate with PTSD, whether and where he seeks treatment, and whether he greets the diagnosis of PTSD with relief or shame. This, in fact, proves to be the main message of this dissertation: The myriad ways in which combat PTSD is understood in American life have a profound effect on the way that

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actually played by participants were often overlapping, in that those who were interviewed as veterans might also be family members, clinicians might also be veterans, etc.

veterans with PTSD understand their own symptoms, feel about their diagnosis, and make what may be life-changing decisions about coping and care-seeking.

I should make it clear from the beginning that not all of the experiences of distress described by veterans in these pages necessarily fit a clinical definition of PTSD. I represent these experiences as veterans themselves described them, without putting too fine a focus on diagnostic distinctions, because veterans themselves rarely made a distinction between symptoms related to PTSD and those of other physical and psychological health problems (for example, a tendency to hyperventilate at imagined or remembered stress, a symptom of panic disorder rather than PTSD). Diagnosis tends to be a concern of clinicians, and since clinicians themselves may differ on whether certain symptoms are associated with PTSD – auditory hallucinations, for instance, or black-outs – I have chosen to privilege veterans' ways of organizing their own experiences. These stories, then, aspire to experiential rather than clinical accuracy. In a sense, this decision reflects a distinction that anthropologists often make between *disease*, or what clinicians identify as the biological problem behind a given sickness, and *illness*, the holistic human experience of living with that sickness.[12] This is a dissertation about PTSD as illness rather than disease.

I should also make it clear that there will be relatively little discussion in these pages of the politics of the wars in Iraq and Afghanistan. One of my early hypotheses for the study was that veterans would describe efforts to make sense of PTSD illness in relation to their views on the merits of the "Global War on Terror" and their role within it. I remember suggesting this to an Army chaplain early in the research, and the bemused look on his face as he smiled and

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[12] (Kleinman, 1988a)

shook his head. He was right; my hypothesis proved wrong. What I found instead was that most of these men were not deeply engaged with the larger national debate over whether the wars were wrong or right, over whether we should bring the troops back home or continue to support the ongoing missions. They never lacked opinions on the subject – they often expressed well-considered views – but these opinions did not emerge as vital to their experience of the war or PTSD itself. In contrast with some of the scholarship among veterans of Vietnam,[13] and among anti-war veterans of Iraq and Afghanistan in other parts of the U.S.,[14] these South Texas veterans rarely describe weighing their own experiences of war in relation to national policy. Their stories were centered around other concerns: the well-being of buddies in the combat zone and their families back at home, their own suffering, their dreams of a good life and struggles to move towards this elusive goal. In all the hours of our conversations, the politics of these wars emerged only at odd moments and on the periphery of other stories, and so they have been left to the periphery here.[15]

These men's stories, however, were profound and telling nonetheless. Over the course of the coming chapters, I will assemble these stories together to form a portrait of PTSD among contemporary American veterans. Doing so provides the opportunity to answer a question that I am asked constantly by those I encounter in the course of everyday doings. The exchange goes something like this. I meet someone at the grocery store or at the post office or while out

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[13] (Michalowski & Dubisch, 2001)
[14] (Gutmann & Lutz, 2009)
[15] I am curious to see whether this may change over time. As the wars continue and public opinion around them shifts, and as these veterans gain distance on their experiences of war, it may be that the righteousness of the wars themselves comes into greater question and takes on a more important role in their organization of war memories and PTSD illness narratives. Susie Kilshaw (2004) has written beautifully on how veterans' narratives of war-related illness may shift over time, and her work would seem to support this possibility.

mowing the lawn. We introduce ourselves and provide some basic information. They ask what I do, and I tell them I am an anthropologist studying PTSD among veterans who have served in Iraq and Afghanistan. At this point, two things generally happen, both of which are important for our purposes here. First, they say that I'm doing good work, that we the American people need to take good care of our servicemen and women, and that I deserve thanks for paying attention to an important problem. They take the local cultural practice of thanking the troops for their service and they extend it (however unsuitably) to me.[16] Second, they ask some version of the question, "What does PTSD have to do with anthropology?" At which point I ordinarily give some mumbled, largely unsatisfactory response.

The difficulty I have in answering this question is not – as it might appear – that I find anthropology speaks too little to questions of veterans' health and well-being in the aftermath of war. On the contrary, I am usually overwhelmed by the ways in which anthropology opens up a variety of perspectives on this issue, and this sense of having too much to say often causes me to say too little. And so, on reflection, it seems appropriate to offer up a more thoughtful answer to what is, I believe, a very important question. This will require talking, at least a little bit, about culture.

Culture in Everyday Life

A cursory look at the history of anthropology as a field would reveal that anthropologists have many ideas about what, exactly, culture is. Recent decades have been full of discussions regarding the limitations of the culture concept, arguing that the idea of "culture" suggests

[16] This is a courtesy that is also commonly offered to VA employees and others who work with active duty military or veterans.

something shared and immovable, leaving no room for variation across individuals or subgroups or for change over time. These arguments have at times become so combative that some anthropologists have called for giving up on the idea of culture altogether.[17] Others have simply proposed a number of ways in which to update our use of the concept, for example, through recognizing what is "cultural" (adjective) rather than suggesting what is immovably "culture" (noun). Nonetheless, although culture is talked about in many ways, it can provide powerful insight into human life and experience.

In the most common usage, culture is defined as the shared thoughts, beliefs, and behaviors of a social group, often expressed through shared language or rituals. For example, Americans have a widely shared cultural practice of standing to show respect when the national anthem is played at a sporting or other ceremonial event. This is something people do, a behavior, but it is based on an idea that the national anthem is a musical symbol of the United States, and a belief that one should show respect for one's country. Thus, many Americans demonstrate this respect by standing when the anthem is played. Ideas, beliefs, and behaviors are all interconnected within cultural systems, which are themselves recreated and reimagined as each generation passes them on to the next.

However, many anthropologists augment this perspective, often called the idealist view of culture, by arguing that culture also encompasses a group's political economy, including its technologies for acquiring food and other necessary goods, via agriculture, industry, fee-based services, and so on. This materialist view of culture includes a society's strategies for distributing wealth and power throughout a population. For example, in most small-scale

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[17] (Interesting considerations of this debate include Clifford, 1988; Knauft, 1996; Sherry B. Ortner, 2006)

societies, power tends to be relatively egalitarian and people are likely to share their resources throughout the community without the formalities of taxation or organized charities.[18] In contrast, large-scale societies like modern nations tend to be highly stratified, with power concentrated among those individuals and groups who control access to wealth. Oftentimes individuals within such large-scale societies find themselves categorized into groups considered to have more or less value according to a system of cultural stratification. These systems, and the social inequality built into them, are usually based on some characteristic considered to be highly relevant in that setting: gender, race or ethnicity, religion, caste, class, sexual orientation, and so forth.

In all of its idealist and materialist manifestations, culture provides a series of constraints placed on human agency, on people's ability to define themselves and the course of their lives in the way they might wish. For example, until recently, an African-American man born of a single mother from a modest background could not reasonably expect to become a President of the United States – there were simply too many barriers of race and class to be surmounted. These constraints have a powerful impact on individual behavior and well-being. At the same time as it creates these constraints, however, culture also provides a set of ideas about human life that form a structure for human experience. To illustrate this, we might think of that shared story often called "The American Dream." The heady message of the American Dream story tells us that all citizens living in the U.S., if they work hard enough and make a certain amount of luck for themselves, can prosper and live a comfortable life. They can earn a home of their own, a marriage and children, and the respect of their community. The American

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[18] (A. W. Johnson & Earle, 1987)

Dream story is so powerful that many Americans order the course of their lives in an attempt to live out this dream. This is what anthropologists mean when they say that human beings live both "with and against culture". Our lives may be constrained by the cultural environments in which we live, but those same environments give us opportunities to make sense of, to make the best of, our lives.

And so it is that human beings call upon culture when dreams fail and expectations go awry. When New York City and the Pentagon were attacked on September 11th, stunned Americans turned to each other seeking explanations for why and how something so horrific could have happened. There were intimate conversations on the street between total strangers. Many people reconnected with family and friends. In these systems of support and efforts at meaning-making, Americans found comfort and the strength necessary to go on. Every culture has its names for solace and suffering, and humans navigate both the pain and the joys of life using the explanatory tools that culture offers.

We call upon culture, too, in facing the more ordinary calamities of sickness and death. Every society has a system of explanations – and usually more than one – for how and why people get sick, suffer pain, disability, or disfigurement, and die. In the United States, dominant cultural ideas about sickness rely on biological models of health and well-being, and on the system of healing known as biomedicine. Many Americans turn to medical doctors for answers, for a diagnosis of illness and a plan for treatment. Members of other societies around the world may understand sickness as the result of a spirit attacking the person, an imbalance between substances in the body, or an unresolved crisis in social relations. Illness, and mental illness in particular, can be seen from a variety of cultural perspectives, depending on the context of time, place, and people involved.

As an anthropologist, then, I see culture as interwoven throughout the fabric of human life. When asked how anthropology can relate to combat PTSD, I find that there are as many possible answers as there are ways in which culture may impact the experience of PTSD. To list just a few:

- *As a reflection of a society's technologies, culture affects what resources – such as oil or water – a nation finds important enough to go to war for.*
- *Alternately, as a reflection of a society's beliefs, culture affects what ideas – such as freedom or democracy – a nation finds important enough to go to war for.*
- *As a system of shared beliefs about the world (including ideas about patriotism and national service), as well as a reflection of social stratification (including what education and career options are available to young men and women), culture influences which members of a society join the military.*
- *As a source of understandings about self and well-being, culture influences how veterans understand what happens to them in combat, and the changes they may see in themselves afterwards.*
- *As a template of ideas about a good and fulfilling life, culture shapes how veterans navigate the transition into the civilian world, and how they and their families judge the success of this transition.*
- *When these transitions are seen to fail (in accordance with culturally-driven expectations), individuals and families call upon explanations of health and illness to name the problem (as in "PTSD"), to figure out how best to cope with it (often through seeking professional treatment), and how to make sense of the suffering and distress involved.*

- *And so on…*

So there are many possible venues to follow in an exploration of the relationship between anthropology and PTSD; over the course of this dissertation, I will consider many of these in some depth. Using such a wide lens to view the many ways in which culture influences the experience of combat PTSD allows the notion of culture to retain explanatory power while remaining flexible and dynamic.

In thus taking on the problem of combat PTSD from multiple perspectives at once, it suddenly becomes possible to see how culture writ large trickles down to affect life at the level of individual experience. Large-scale forces – for example, the way that Americans understand and interpret ideas about male gender and war-related illness, the professional controversies that define contemporary mental health care, and the cultural politics surrounding the U.S. military and the VA – may have a profound, immediate, and long-term influence on the personal experience of combat PTSD. Part II of this dissertation, *Crisis and Response*, focuses on these large-scale forces and the arenas in which they act upon veterans' lives: within their families and communities, within the U.S. military itself, and within the VA.

But before turning to the task of examining how PTSD exists as a fraught social phenomenon, the source of conflicts and debates that continue to rage, I begin by examining PTSD as an illness that comes into, and profoundly shapes, individual lives. For all the clinical and political debates that make combat PTSD such a charged topic, it is in the private space of veterans' hearts and minds that PTSD takes its toll.

Over the course of this and the next two chapters, then, I will follow the roughly chronological arc of how veterans in the PDS study found themselves signing up for military service, their experience in conflict zones, and the subtle and dramatic ways in which they found

themselves changed and troubled afterwards. Amidst all the possible ways of revealing the many faces of PTSD, this seems the most direct method of demonstrating how PTSD enters into lives that were already in motion, already speeding along rapid trajectories towards an unseen but surely promising future.

The Fourth of July

In age of the All-Volunteer Force, individual Americans must make the choice to join the military, and generally they do so with some at least abstract awareness that this may mean going off to war. The reasons they give for making this choice say a lot about both the worlds they are coming from and where they hope, upon enlisting, that the military will take them. More than that, however, they reveal how the tradition of military service has remained firmly embedded in some sectors of American society, even as the 1970s shift to an all-volunteer force has resulted in a growing cultural separation between the classes of civilian society who join the military and those who, for the most part, do not.

Although my grandfathers were veterans of Korea and World War II, I grew up in a small community in rural Maine where veterans were not often visible and joining the military was a rare thing. As a result, it was not until I attended that Fourth of July memorial at the San Antonio VFW Post that I first began to appreciate how deeply this tradition is rooted in South Texas life. More than anything, it was the multi-generation parade of it that I found striking - the families gathering together to honor those who had lost their lives, while little boys played on the dusty ground and older veterans rehearsed familiar habits of doffing hats and standing at attention.

Tucked back off a side road down by the San Antonio River, the VFW Post is built like an old Southern manor, with rounded front corners and a long white porch wrapping the façade. The woman I met there, Melissa, and I got to talking about the sun, the rain earlier in the day, and the heat of July in that part of the country. She was in her fifties, and wore big sunglasses and a pendant shaped like a tiny gold dogtag, with a man's profile engraved on it.

In the area around us, towards the side and back of the Post, speakers had been set up around a stage area where a local band was set to perform later that night. Picnic tables painted in bright colors were set up to the right side, and a mobile taco stand had moved into the opposite corner. A long folding table stood beneath an awning beside the Post's front porch; on it, bricks to be dedicated in the ceremony were laid out in neat rows, each engraved with a name, rank, and unit of service. A group of Cub Scouts was clustering around the table, a small herd of little boys in uniforms.

The ceremony began with an announcement over the loudspeaker, so I excused myself from Melissa and moved up towards the front. The podium from which the Master of Ceremonies was holding court had been set up about 20 feet from the Post's front porch. A line of VFW officers marched around the front of the building and took their place as the ceremony began, standing taut at attention in their loose uniform of white shirts or black polos with the Post's insignia stamped on chest and shoulder.

While Melissa and I were talking, folding chairs assembled in rows on the front porch had gradually filled with men and women who were now introduced as Gold Star families, those who had lost sons, daughters, parents, and spouses in the war. The ceremony's officials and the Gold Star families sat facing one another across center stage, and onlookers were left to take their places along the side of the open area, scattered across the driveway and in amongst the

picnic tables. Despite the morning's cool and rain, it was the hottest day of the summer so far, and the smell of frying onions wafted out from the taco stand on a muggy breeze.

The ceremony opened with the national anthem, and the crowd stood, those in uniform removing their hats respectfully. Many sang along, softly. The anthem was followed by the Pledge of Allegiance, the crowds' eyes turned upwards towards the center flagpole, its flag dark against the bright sky. There was an invocation prayer. Then the MC gestured the day's speaker, a retired Army General, to the podium and he began the memorial and dedication, slowly reading off the names and ranks of those who had been killed.

As every name was spoken, an engraved brick was carefully lifted off the table by a VFW officer and handed to one of the Cub Scouts, who had formed a line along the table. The boys looked to be between the ages of five and eight or nine, and many of them were so small that they had to hold the bricks against their chests with both hands as they carried them. Clutching their burdens, they walked in a staggered line past the podium and past the Gold Star families on the porch above to where another VFW officer stood waiting. The officer took a brick from each boy, solemnly, with a stiff little bow, before turning to place it down in a tight configuration – laying, piece by piece, a base for the flagpole. Each Cub Scout, relieved of his charge, walked on to be met with a grin and a gentle slap of the hand by another VFW officer, a Native American man who stood waiting beyond, with a beaded dream-catcher around his neck and a walking stick hung with feathers in one hand. Every boy passed him before returning to rejoin the line alongside the canopied table, waiting in turn to carry again. Some of the smaller boys, as they passed the man for the third or fourth time, became visibly excited about getting to slap his hand, running towards him and hopping up with a wild swing towards his outstretched palm.

Even in such a funereal atmosphere, the older man had a hard time suppressing a smile at their glee.

As each brick came out and the name written upon it was read by the General at the podium, the service member's family rose to their feet. Some shed tears, but most did not. A blond woman in a hot pink blouse sobbed helplessly, supported by the woman beside her. There was a tall Latino man in a yellow polo who, when he stood with his family, carefully wiped his eyes. A handful of the Latino families wore oversized t-shirts printed with the name and a photo of their warrior on the front – one couple wore the face of a man with a firm look in his eyes, his shoulders proud under his Marines uniform.

More than fifty names were called, all belonging to individuals who had died in Iraq or Afghanistan or elsewhere in the Middle East, all of whom had ties to the San Antonio area. The bricks were stacked on one level and formed, in the end, a rectangle about three feet wide and five feet long – smaller than a coffin. Oddly small to represent so much life.

As the General brought the recitation of names to a close, he leaned over the podium and said, 'When you command a young soldier, you feel responsible for him.'[19] He told the families on the porch that those who have died are a highly select bunch, because they have been chosen not only to serve in the military on Earth but also to be members of the Army,

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[19] All text in double-quotes is taken directly from the transcripts of recorded interviews. All study participants completed informed consent and were then asked whether or not they would mind if the interviews were audio-recorded; most had no problem with this and these interviews were recorded. Text in single-quotes is drawn from unrecorded interview or observations, signaling conversations reconstructed from detailed notes. Interview quotes have been edited primarily for length, although I have also taken the liberty of removing pausing phrases such as "like", "you know", etc., where they recur with some frequency. In certain cases, I have corrected minor mistakes in grammar if I felt these created unnecessary confusion. Some edits have been made for the purpose of removing identifying names or facts, and these edits are marked by brackets. I have also used brackets to indicate places where it seemed necessary to include additional information for the purposes of clarifying a quote.

Navy, Air Force, and Marines in Heaven. He said that we are living in a semi-divided country these days, and that we must not allow these divides to undermine the troops, a statement that earned a hearty round of applause from the gathered crowd.

He then stepped down, and the Post Chaplain said a closing prayer. A trumpet played Taps, and as the mournful notes sounded, hats were again doffed and everyone lowered their heads – with the exception of one boy of about four who had settled himself in the dirt in front of the line of VFW veterans, and of several clowns who came tramping through the gate just then in full kaleidoscopic regalia. The MC announced that there was food available free in the banquet room or for sale from the taco stand, with clowns for the children and plans for music and dancing later in the evening. The line of VFW officers made an about-face and marched back around the building, and the ceremony was over.

There was a moment's hush, and then the crowd began to scatter. As I walked away up the driveway, I noticed that the picnic tables were full now – the crowd seemed to be growing rather than diminishing – and a number of kids had gathered over by the clowns, in the area set up for dancing later in the evening.

Later that night, several friends and I went out for a drink along the Riverwalk, San Antonio's waterfront tourist area, where the San Antonio River is lined on both sides with shops and restaurants. All the tables along the river were full to capacity, and it took us a while to find a place. Moving slowly amidst the crowd, we passed a family sitting together, a group of three or four adults with a few small kids. At the head of the table, facing us, was a good-looking young man and, at first glance, I thought he was wearing some kind of funny collar. I looked again and saw that he was badly burned, with thick vertical bands of scar tissue encasing his neck.

We kept moving until we found a garishly-lit bar called “The Republic of Texas”. We sat there and drank bad sangria and margaritas (“Texas-sized!”) for a while, watching the families come and go around us. Our table, as it happens, was situated at the base of a stairway leading to a pedestrian bridge over the river. After a while, I looked up and saw the young man with the burns and his family making their way towards the stairs. At the first step, he stopped and knelt down. Taking one of the smaller kids by the hands, he pulled the giggling boy up onto his back and carried him up the stairs. It was a small gesture, but it seemed to close a circle begun earlier in the day. First the skittish, shy, gleeful Cub Scouts in their uniforms, carrying bricks too heavy for them. The bricks themselves, with their encoded tales of loss and sacrifice. The faces of the Gold Star family members, blank or teary. The VFW veterans with their uniform and memorials. And now, this young man with his face clear and smooth but his body a testament to what can be survived, hauling another little boy up the stairs on his back.

On the drive home, around midnight, we passed the VFW. The lights hung around the bandstand were still on, although it was too dark to see if anyone was dancing. I thought about the memorial service late into the night. Even in the context of a ceremony honoring the dead, confronted by the grieving families of those who had lost their lives in the line of duty, there were little boys running around giddy at the pageantry, and older veterans re-enacting the marching and hat-doffing of their youth. The tradition of military service hung thick in the humid air, a heavy tapestry of hope and promise and sorrow and sacrifice.

Growing Up and Joining Up

Although all of the veterans in the PDS study were living in the San Antonio area in 2007-2008, only about half were born and raised in Texas. Of these, there is a roughly fifty-fifty

split between those who grew up in San Antonio and those who were raised elsewhere in the state.[20] A few of the non-San Antonio Texans were from cities like Dallas, Houston, or El Paso, but mostly they came from rural towns scattered throughout the state. Mirroring Texas' demographic split, Latino veterans were more likely to have come from primarily Mexican-American South Texas, while white veterans were more likely to have come from the Northern or Eastern parts of the state.

Those who were born elsewhere came from across the United States and Puerto Rico, from Michigan, California, Oklahoma, Missouri, Louisiana, South Dakota and so on. They came from both cities – San Juan, New Orleans, Detroit – and small towns – Ruidoso, Claremore, Rock Springs. Almost all came to San Antonio through their military service, although the routes differed. Many found their way to South Texas for the first time as part of their military training at Lackland or Ft. Sam Houston, returning later because they liked the area or thought they could find work here.[21] Brooke Army Medical Center (BAMC), located on Ft. Sam Houston in the northeastern part of the city, provides healthcare for all service personnel in what is called the "Great Lakes Region" of the U.S., which covers the entire central portion of the country, and so other veterans were shipped to BAMC for treatment after suffering an injury or other health problem while in the service. Many of these veterans, particularly those seriously wounded while on combat duty, had chosen to make San Antonio their home during the long period of

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[20] Of 62 participants in the veterans' group, 32 reported having been born in Texas. Of these, 15 individuals were born or raised in San Antonio, while 17 came from elsewhere in Texas.

[21] For example, Ft. Sam Houston has a long history of providing medical training for Army medics and other health providers. In 2005, the Department of Defense's Base-Closure and Realignment Commission recommended that Brooke Army Medical Center (BAMC) and Wilford Hall be merged to form the San Antonio Military Medical Center (SAMMC). The combined facilities will in future provide medical training for all medics and other health professionals across the Armed Forces.

recuperation and rehabilitation. Another group of veterans found themselves in San Antonio following friends from the service who knew the area, hearing it was a cheap place to live or wanting to be close to their buddies.

San Antonio is often jokingly described as the "northern-most city in Mexico" because of its majority Mexican-American population – the 2000 U.S. Census found that the city is 58% Latino, alongside 32% non-Hispanic whites, and 7% African-Americans[22] – but it is better characterized as a place of vivid cultural fluidity. The city of 1.3 million people[23] incorporates influences from the conservative American South and Midwest and, closer to hand, the liberal capital of Austin to the east, the historically German Hill Country to the north, ranching and oil country to the west, and the Rio Grande Valley to the south.

Those who have grown up in San Antonio describe a city in transition. Beto, an enormous Marine with giant shoulders and a wide gentle face, grew up on the West Side, a predominantly Latino area adjacent to downtown, known for high rates of poverty and crime. Describing what it has been like to return home after his time in the service, he says:

"It's changed a lot since I've been away. The neighborhood, the city used to be more dangerous. It was more gangs, more things to be worried about. A lot more drugs, more violence out there. Since I came back, it's there, but I see more police, neighborhoods looking better, people trying to help out. The neighborhood I grew up in, I could point to each house and tell you what drugs they were selling. It's not like that anymore."

I was surprised: "That big a difference in 10 years?"

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[22] (Brookings, 2003)
[23] (USCB, 2007)

"I just know my neighborhood, but things are nicer. The yards are nicer. Downtown has seriously changed. It used to be real run-down, but they've rebuilt a lot of things. Hotels. Nicer restaurants. Places that were run-down that had a lot of homeless people on the corner, that they've renovated. So things have changed a lot since I was growing up."

Many of those who grew up in the urban world Beto describes chose the military as a way to escape poverty, and at times, to move past early forays into crime and violence. Tony, another former Marine, told the story of growing up "rough" on the South Side, exposed to "a lot of drinking and a lot of violence." He said, "It's a recipe for failure, you know? And I was falling into it." At 21, he was arrested for a DUI, and was on probation for 6 months. As soon as his six months were up, he signed up for the Marines. "I was going in the wrong direction before I joined the Marines, and that gave me more reason to get out of there."

Carlos was in the Air Force until an injury he sustained in Iraq forced him to retire. He was born in rural Texas, but his family moved to San Antonio in the early 1980s. Carlos says, "At the time when we moved, San Antonio had a lot of crime. We saw a lot of people shot and injured and stuff like that." As a teenager, he got involved with a local gang, although he says he got out of that fairly quickly, joining the military as soon as he finished high school.

Other veterans also described seeking out military service as an escape, and not only from violent urban environments. Jerry grew up in rural South Texas, helping out his ranch-hand father from the time he was eight years old. He grew up working in the family's grocery store, which was the center of commerce for their small town, and also contributed to the family income by running a business doing odd jobs on the side. By the time he was 16, he was working 4 jobs. He joined up in September of the year he finished high school, because "I wanted to get out of that town. I wanted to do something. I always wanted to be an Army guy,

a soldier." It was a dream that sounded good to him, an opportunity that seemed a lot bigger than the town where he grew up, although he admits now that, as a kid, "You watch movies, and [military service looks] totally different from what it actually is."

There is a strong sense of either/or in these stories, for military service was one of very few options for many of these men. I was surprised at how frequently people around the area reiterated this point, even those who had chosen other paths. One day I ended up talking to a salesman at Macy's after he commented that he couldn't place my accent. I said it came from 'moving around,' and he asked if I was in the military.

'No,' I said, 'but that's a good guess around here.'

He said that he was from San Antonio, and that his whole family is military – 'My Dad, uncles, cousins, everybody.' He said that he was the only one who didn't want to go that route, that – as though there were only two options – he 'went to college instead.'

'A good alternative,' I said.

'Yeah,' he laughed, 'and safer.'

I heard the same thing from two local clinicians, both Mexican-American, both very successful in their professional careers. The first one, a psychologist who grew up in San Antonio, told me that many young Latinos use the military to get out of the *barrio*, and that his father and uncles were all in the military. He said, though, that he had 'known better' than to go that route. I asked how he knew, and he said that his father told him to stay away from it. So he, like the salesman, went to college instead. The other psychologist, a tall light-skinned Latina with a wry grin, told me over lunch at Cracker Barrel that she had grown up down in the Valley. She described it as being a hugely military area precisely because it is so poor. She said that the recruiters go to all the 'sorriest' high schools, and that for a lot of those who sign up, the military

is their 'only way out.' She snorted, and added that she hadn't even known college was an option until she was almost a senior in high school.

For young men and women from poor or underprivileged backgrounds, then, joining up may represent a choice among somewhat limited options. There is no longer a draft in the United States, but even in an "All-Volunteer Force" some volunteers are more voluntary than others. The disproportionate recruitment of service members from among low- and middle-income communities,[24] and the reliance placed upon the less privileged to sacrifice their lives toward the advancement of national interests, is a classic example of structural violence, that subtle process by which social inequalities take dramatic shape in the form of differential health and well-being.[25]

In contrast to those who chose between military service and college, another group of veterans entered the service as a way of accessing education. Todd, a young white man from outside of Dallas, volunteered right out of high school. He said he knew that his father, a fireman, could not afford to send him to college, and figured that between the GI Bill and the Hazelwood Act, he would be able to get an education if he enlisted. Some of the veterans who had joined when they were older described a similar decision-making process, choosing a term and branch of service that would provide them with desired schooling or career training. I met one man in his late 20s who had joined the Marine reserves in order to get his degree in nursing, and then signed up for the Navy Reserves as a way to finance a shift into dentistry.

But to focus solely on the material benefits of military service would be to vastly oversimplify the decision to enlist, a decision that means giving up considerable freedom in

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[24] (NPP, 2009)
[25] (Galtung, 1969)

order to commit to, if necessary, putting life and limb in jeopardy on a foreign battlefield. The Navy Reservist made this clear as we sat and talked about the fact that a lot of people join up to get their education paid for. He told me that he had another year before graduating, then one more year of advanced training, and then he would owe the Navy four years of service. I asked if he will be eligible for combat deployment (as opposed to a non-combat deployment to somewhere like Guam or Korea) and he said yes. He listened mildly as I chattered along about how my niece, also in the Navy, had gotten her orders for Iraq just about the time she got her discharge papers. I started doing calculations aloud that, if he had two more years in school, maybe he wouldn't have to deploy. Maybe the U.S. would be out of Iraq by then. He laughed at me a little, nicely enough, and said, 'Well, I didn't join the Navy to avoid deployment.'

Point taken.

Towards the end of the time I knew him, Beto laid out a more tangled knot of reasons for joining up, giving greater substance to his decision than in earlier-quoted comments about just wanting to get out of the *barrio*. I asked him again, "How did you end up in the military?

And this time he answered, "A recruiter came to the high school, and someone said, 'You go talk to him, you can get out of class."

He grinned at this, and went on. "I was like, well, why not? They keep hassling me at the house, I might as well get out of class. I see the Navy and the Air Force people around there all the time. And the Army - you got Ft. Sam right around here. I wasn't interested in them at all. But being in the Marine Corps, being in the Navy interested me a lot. That's what I wanted to do - go to other places, learn. I figured if I can't go to college, I might as well educate myself. [The recruiter] was real talkative… I liked what he was saying, his appearance. It got me thinking: if I can do the hardest branch of service, then I can do anything. And I was in my senior

year, halfway though, and I was like, 'Alright, sign me up.' And get me out of here. Money for college, too, so I figured - I'm working, making a paycheck, learning a trade, and paying benefits. It didn't seem like there was anything bad to it." He grinned again. "Until you go."

Beto's story revisits two of the reasons for enlisting that I have already discussed: a way out of a rough neighborhood (or small town), and a series of options for education and a career and benefits that were better than anything else around. He also hints at some glimmer of a future self that he saw reflected in the recruiter's manner and self-presentation ("I liked his appearance"). There is a sense in his words of a promise to himself, an act of faith that, "If I can do the hardest branch of service, then I can do anything." Many veterans chuckle as they admit to an early fascination with how soldiers or Marines are portrayed in the movies, or to being awed by a particular uniform, but there is something seriously captivating in these images that grab them, some vision of a future that might be theirs.

Will – a skinny white man who looks much younger than his 27 years – grew up with three brothers, raised by a single mother in a trailer park in rural Texas. His mother worked all the time, so when he was home from school he mostly watched TV. When he was 12, his mother was finally able to get them into a house, where they lived for a while. One of his mom's boyfriends was a former Navy Seal. Will sums up his decision to enlist this way: "He [the Navy Seal] was always talking about it, and I was real patriotic so I joined the military."

But it was not simply patriotism that led him to join. After high school, Will did odd jobs. He worked construction, hung wallpaper. He was a cashier down at the gas station for a while. "Nothing important," he says. But the ex-Navy Seal kept talking about his experiences. "He was a really short guy, but really respected by others. It made me want to join the military."

"Why?" I asked.

"Because I wanted to see if I could handle it physically and mentally." In contrast to the life he had led so far, with no father, little stability, and odd jobs that were "nothing important," the Navy Seal laid before him one option that offered simultaneously the means of serving his country and a way of gaining respect and testing himself.

Still, we shouldn't forget the sheer high-adrenaline fun that many young men, in particular, associate with joining the military.[26] Brian, a middle-aged Army Reservist, talked about how he wanted to go into the military even as a little kid, irresistibly caught up in the masculine adventure of it. "They have cool uniforms, and you get to shoot things. Just very manly stuff!" He told stories about his younger son, who at eight was already ready to sign up, falling asleep each night with the Military Channel on the TV in his room. "We go out and play paintball, and he'll go out there and play paintball and he's getting shot at and he thinks it's the coolest thing in the world. And we go camping. We go shooting a lot. We go down to the farm and go shooting and he's got all the regular weapons. The .22 rifle that's his. Just one of those kids. Destined!"

More often than not, veterans acknowledge some confluence of all these reasons in describing their decision to join up; they admit to having been concerned with both the honor and excitement of military service and also with its more practical aspects, the economic and educational benefits.[27] Brian was exuberant about the fun of military service for himself and his

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[26] I'm associating this youthful desire with young men and masculinity here because Brian and some of the other veterans do. However, as a pig-tailed girl of 9, I was obsessed with Tom Wolfe's The Right Stuff and wanted to be a Navy test pilot even more than I wanted to be a ballerina. As an issue of face validity, we should perhaps be hesitant to link the desire for adventure too closely with masculinity.

[27] The primary exception I find to this generalization is among those who joined up in the wake of the attacks on September 11, 2001. A small group of veterans describe enlisting 'because of 9/11.' Upon further discussion, however, these men usually revealed that they were already in the process of enlisting at the time, or that they had some previous link to the military, such as ongoing participation in the

younger son (who is still ten years too young to actually enlist). But when he described his own decision to enlist – and later on in the time I knew him, his older son's – he talked about the impossibility of raising a family on a minimum wage salary, and about the military as an opportunity for career-building and vocational training.

And finally, for those with family or other social ties to the military, the decision to join the service was often described in relation to those ties. Carlos' father was a Marine in Vietnam before becoming an engineer. Carlos reported that his father was proud of his three sons when all of them decided to enlist; he was even more proud when he learned that Carlos had decided on the Air Force over the Marines, as there was less chance of him "getting killed". A woman in her 40s who I met on a plane out of San Antonio – I couldn't understand why she was peering over my shoulder at an article on combat PTSD until she introduced herself as a psychiatric nurse for the Air Force – recited a long string of her carefully considered reasons for joining the Air Force in her late thirties: there was still time for her to serve out a full twenty years; the Air Force would pay for her masters degree; the benefits were good. Even so, it wasn't until she began talking about her husband, who had completed his career in the Army, and her father, who was also a veteran, that she began to speak with any warmth. She said that she was the only one of her father's children who had gone into the military, and that it 'meant a lot' to him to see her do it. Speaking proudly of her husband's service, she said that 'he's the face I see in front of me and the boot in my rear,' both her inspiration and her support on this chosen path.

And this family history may itself be a source of pride. Brian pointed out with some satisfaction that, "There's been an O'Neil from my direct ancestry in every war that's been

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Reserves or an ROTC program at their high school. I clarify this point not to undercut the patriotism of those who enlist, but rather to give proper weight to the complexity of their decision-making process.

fought since the beginning of America." Derek, a biracial soldier whose left leg was amputated after an explosion in Iraq, had no regrets about his service, despite his loss. He, too, felt his time in the military placed him in line with his ancestors, since "all of the males in my family as far back as you can count have served in some capacity."

Never is this pride in military service more clear that at events like the Fourth of July memorial ceremony described earlier, or down by the Riverwalk on graduation day for Lackland's basic training program, when the streets are flooded with slim young men and women in their brand-new cadet uniforms, awkwardly showing their family around the sites of the city where they became Airmen. On one of these graduation days, I found myself sitting at a local café, and noticed through the front window a young white man and his mother walking up to the door. He looked so young – without the uniform I wouldn't have said he was 17 – but he stood tall in his Air Force blues. His hair was shaved close to the scalp, with a fresh nick gleaming through on one side. He was new enough to the uniform to still be clumsy with it, dropping his cap on the way in and dragging the sleeve of his coat on the ground as he stooped to pick up the cap.

But as he and his mother walked in through the café's entrance, the blond woman working behind the counter said, 'Hey Mark! Oh my God! You look so official!' Mark's mother laughed and said, 'He looks so bald!' The guy standing at the cash register said, 'Did you graduate today?' and Mark nodded. The blond woman came out from behind the counter to give him a hug and make a fuss over him. She congratulated him, and said, 'Your Dad must be so proud! Where is he? Couldn't he be here? Where are you going?' He told her about his first duty assignment with all the serious, self-conscious detail of the newbie, while his Mom stood back and grinned, watching his face. The blond woman said, 'It's so good to see you!' He

replied, 'I know! This is one of the places I wanted to come,' meaning - I think - to show off his new uniform. He told her about his time away at basic training, and how much stress they put on him. He blushed a little as he spoke.

A middle-aged Latino man working on his laptop nearby sat watching the scene as I was, grinning. The boy looked so young and so brimful of happy pride that it was impossible not to smile, although I, at least, could not see the flush in his cheeks without thinking of all the boys like this that the U.S. has lost in the recent wars, some nearly as young, many of whom must have had moments like this. As a lump rose in my throat, the boy recognized the man with the laptop and went over to him. They shook hands and the man congratulated him on how sharp he looked. Then Mark and his mother and the blond woman all sat down to eat cookies that she refused to let them pay for, and she remarked that he had lost weight. 'You've gotten so skinny!' 'Doesn't he look skinny?' his Mom agreed. I heard him bragging shyly, as I turned back to my work, 'Well, I've been working out a lot…'

War Stories

Case Studies of Combat Deployment

Chapter Two

"My mind is either thinking about the present or that period of time [in Afghanistan], which was less than a year of my life, which consumes 85% of my thought today. The event becomes the hinging point in your life. Everything that happens now – even sitting at this table – is kinda based on what happened then." - Air Force veteran Christopher Monroe

This chapter introduces four veterans who describe their own experiences of war in Iraq and Afghanistan in the months and years following 9/11. These four veterans – although all male, all American, all combatants – make it clear that that war is a big enough territory to leave room for a wide variety of experiences: combat and quiet, anger and love, peace and boredom. This is not a new observation. Most war movies have their token scenes depicting funny things that happened on the way to the land mine and the camaraderie between brothers-in-arms, bright moments amidst the irregular storms of attack and counter-attack. The war stories retold here reflect that same complexity. They are as often humorous as they are sad, describing joy and pride as often as they do horror and grief. For many veterans, their time in Iraq or Afghanistan was one of the highlights of their lives, even as it may also be what Chris Monroe called the hinging point, the period of time that separates some division into "before" and "after" in their lives.

In approaching these stories, it is important to note that going to war does not mean suddenly stepping outside of life as we know it. Wartime may, in many ways, be an aberration in the course of a life – a period of time different than any other – but it is still part of that life course. A soldier's time in Iraq or Afghanistan is as deeply shaped by his own personal history as it is by the gun (or mechanic's wrench or medic's kit) he carries with him into combat. Throughout these stories, I have left in the parts that too often get skimmed over in war movies: how the service member came to be in a conflict zone, key aspects of his life before deployment, and the people he left behind at home. When it comes to combat PTSD, there is a tendency in casual discourse to talk *only* about combat, as though entering a war zone is like passing through a portal that suddenly deprives the service member of a past and present aside from war. Hearing from veterans themselves, particularly in quotes like Chris' above, it is easy to understand why we might think this. For civilians, for those who have never been in conflict, war is enough of a mystery that we can easily imagine it as a vortex that erases all else. These stories, however, insist that we think more carefully about this tendency. War may be all-consuming, but it is impossible to understand the experience of combat without understanding the richness of life going on around it.

There is one last thing to point out before beginning, one more commonality among these four male American combatants: each of them came home to find themselves struggling after the war, and each of them ultimately received a diagnosis of PTSD. As a result, in and amongst these varied stories we find some of the events these veterans would later came to think of as "traumatic," the memories that would later be blamed for their PTSD. For this is in essence what "Post-Traumatic Stress Disorder" means: an event occurred that caused enough distress that it led to psychological, physiological, and emotional disorder in its aftermath. Any

mental health clinician making a diagnosis of PTSD must first identify what the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) – the manual that psychiatrists and psychologists use to determine a diagnosis – calls "Criterion A," or "the stressor." There can be no PTSD without trauma, just as there can be no war stories without war.

But before any of these events were called traumas, before they got recognized as some distinct kind of experience capable of causing mental illness, they were just things that happened. They were just war stories.

The Medic

I met Brian O'Neil[1] because of an ongoing joke between him and his boss. Brian had given his boss a phone number and told him to call it, saying it was the number to get a free DVD from Best Buy when it was really, as he put it, a "gay love hotline." Texas office humor. A short time afterwards, his boss picked up one of the fliers I had posted around the VA, advertising for participants in a study about post-deployment challenges for recent veterans and their families. Brian's boss tore off one of the strips listing my contact information and threw it

[1] Each of the key informants discussed in this chapter, and returned to throughout the dissertation, represents a composite of several individuals. After much consideration, it became clear that no simple change of identifying facts (dates, places, occupations, etc) would be sufficient to honor the spirit of the confidentiality agreement made when study participants and I conducted these interviews together. Instead, I have chosen to disguise these individuals by creating a composite of several identities, while working to remain true to the integrity of the original stories. This tactic has the additional benefit of offering maximum depth and complexity (by representing a variety of experiences) alongside minimum confusion (by avoiding an endless string of names and offering a more substantial portrait of particular individuals). Each of these composites, in turn, represents a particular pattern of approaches to the experiences of deployment, life after deployment, and PTSD that emerged in the larger set of veterans' interviews; each was selected for its ability to articulate and represent these common concerns and perspectives.

on Brian's desk. "What's this?" asked Brian. "It's a study about PTSD," said his boss. "You should do it."

So Brian called and left a message on my voice mail, thinking it was another joke. By the time he talked to me, he told me later, he had figured out it was for real, but he told me the story anyway, laughing. Brian laughs a lot. He is in his early forties, medium height and a little husky, with blond hair and ruddy skin. He seems like the guy who got along with everybody in high school – smart, easy-talking, sensitive to what is going on around him. The first few times we met, it was in the same room where I interviewed most of the veterans, an office on the eighth floor of the VA hospital, a stuffy white space dominated by a laminate desk and decorated with two framed pictures of Raphaelite cherubs hanging on the far wall. At the beginning of the study, I was strictly instructed by the clinicians and nursing staff I worked with to sit by the door, where I would be able to make a quick escape if one of the 'patients' became violent. So I sat on one side of the desk, by the door, and any visiting veteran sat across from me, his back to the opposite wall. From my vantage point, the two cherubs hung on either side of the veteran's head like a pair of slightly bored-looking guardian angels.

Brian grew up fascinated by battles in faraway places: "My uncles were both in Vietnam and I can remember my older uncle being in Vietnam and his younger brother was in Guam. And my uncle would send things home like – you know, we all had toy M-16s back then. And he would send TA-50, the web-belt stuff. And he would send things home, like he sent my grandfather a bayonet and I can remember that bayonet."

Brian's father was also in the service, and he remembers growing up with the idea that military service was a duty: "your democratic obligation to serve." In the mid 1980s, after years of buying fatigues at the surplus store and debating the merits of Army vs. Navy, he found

himself in a recruiter's office, signing up to be a combat medic for the Army. He was sent for medical training to San Antonio, where he met his wife, Lisette. For the next eleven years, they lived on military bases in North Carolina, Georgia, New York, and Germany, having two sons and a daughter along the way.

He was sent to Iraq in the first Gulf War, the news of his impending deployment coming out of the blue one day in 1990, when he was serving as a medic attached to an artillery unit in Germany. They were out on the firing range, in the middle of practice, when the battalion commander and the battalion sergeant major pulled up in their Humvee.

"They sent everybody to the chow hall. So we all get out of our vehicles and walk to the chow hall and they flip on the TV, punch on the VCR and put a video in, and they start showing Kuwait being invaded." The video showed Kuwaiti tanks clustered protectively around the main palace in Kuwait City, under attack by Iraqi forces. "And they're firing and firing and firing, and they move in to cover each other and another one blows up. And the whole time they're defending an empty palace, because the King and his whole family had already been gone. But these Kuwaitis and their Army…" – he interrupts himself – "I get chills thinking about it…are defending an empty palace because they want the Iraqis to think [the royal family is] still there so they don't shoot down their plane when it takes off. And you're watching this and thinking, 'My God, you know, the *duty*.' And then you're pissed. Those bastards, they went and attacked Kuwait.

"The sergeant major gets up in front and says, 'Boys, I'm not going to lie to you. If anybody goes to war out of this theater it's going to be y'all.' And the battalion commander comes up and says, 'Y'all need to prepare yourselves, because I guarantee everybody in this room – even you support guys,' talking to us [the medics] and the mechanics – 'are going, and

you're going as a package.'" Brian pauses before continuing. "That was August 2nd, on the day they were invaded. And so November 17th we sent our vehicles, and we left on Christmas Day. And so December 25, 1990 we left. And five days later my oldest learned how to walk."

He admits that, when he joined up, he had never expected to go to war, much less in a desert. He says, "I used to laugh. I'd spent all my life preparing to fight Russians and the only place we ever fought was in a desert." He still marvels at how long it took for the Army to catch up with the new realities of war, pointing out that even though his unit was far forward during Operation Desert Storm, they were among the last of those deployed to replace their forest green uniforms – which didn't provide much camouflage in the beige Iraqi desert – for the "deserts" that quickly became a familiar sight on the American news. "Literally, I got my desert uniform three days before I got on a plane and came back to Germany. It was the dumbest crap I'd ever seen."

All the usual jokes about Army incompetence aside, the first Gulf War remains clear in Brian's mind. His voice is steady, matter of fact, as he says, "In Desert Storm, we killed an entire battalion of people in one night, in less than an hour. Two hundred and eighty people died because they shot at us, and three days later I had to go back and help bury every one of them. And the engineers come in and dig a big pit, and you're going through these guys' personal effects and bagging everything up and tagging them and putting down where you're at and that stuff. But you're pulling basically their lives out of their pockets, and you got pictures of their wives and kids. Iraq is very cosmopolitan..." He halts for a second, "Well, *was* very cosmopolitan for that region, because even those little towns, they had lights and generators and streetlights and normal things. And you drive in and people are shooting at you, so you blow the town to hell. It was weird seeing those guys and they're dead and they're wearing

stuff like Knicks' hats and they're very Americanized. And they were probably conscripted off the street and we went and killed them."

Brian says that he didn't have any problems after coming home from Iraq in 1991, which he attributes to the fact that he was still on active duty then, still surrounded in day-to-day life by the other members of his unit and by all the support services the military has to offer. A few years later, in 1998, he left active duty. He had run into some staffing and management problems in his job at the base hospital. He says that, "I came home complaining one day and my wife said, 'You know, when we did this, you said that when it's not fun anymore you were going to quit.' I said, 'Yeah?' She said, 'Well, it doesn't sound like it is very fun anymore.' I said, 'You're right.' And so that's when I quit."

He and his wife started applying for jobs, and both were able to find something in San Antonio, where she grew up and where her family lives. They moved down there with the kids, and Brian transferred over to the Army Reserves, meanwhile working full-time for a local medical contracting company. In 2002, he was deployed as a Reservist, this time to Afghanistan for eleven months.

He served as a medic with a reconstruction team in the southern part of the country. His unit fulfilled a number of functions in the area, doing daily presence patrols, combat patrols, and taking care of general health and wellness on the post. He was attached to a Civil Affairs unit, conducting water and sanitation assessments for local villages. "We did all kinds of hearts and minds stuff. We gave 'em all their school supplies. We did a lot of humanitarian aid drops. We filled the back of a truck with soccer balls and went around town and kicked them out on Christmas morning. Those kind of things."

He says that Afghanistan was the best job he ever had, at least in the military. "I could get up in the morning and be on combat patrol in the morning, in the afternoon be on a humanitarian aid drop, and by evening I'm going down to a village to do an assessment of their well, or getting them a well built. It was so varied – or teaching an Afghan how to drive a Ford tractor. You never knew what was going to happen every day. It kind of makes it interesting. It kind of scares the crap out of you too, but you know, you've got a road block and you're checking every vehicle and somebody starts shooting at you, you're like, 'Ok, that's what's in store today.'"

His deployment to Iraq, later, was a similarly challenging experience. Head of a team of medics stationed in Iraq, he used to volunteer to go on public relations missions. He liked it because it involved going out to give food and candy to Iraqi children: "It was nice to make a kid smile." Still, he says didn't mind getting tapped for combat patrols and kicking down doors when necessary. It was better than being stationed at one of the big camps out by the Baghdad airport, where most people only go "outside the wire" – in other words, they only leave the (relative) protection of the Forward Operating Base (FOB) – to go on convoys. Too many of those people get excited, he says, about the idea of seeing a roadside bomb. When he drove down to the FOB to collect a new unit of reservists on their first deployment, he found it hard to convince them that life was going to be different once they left the FOB.

That became pretty clear, however, when he and the new team went up to the northern part of Iraq. His voice is slower when he speaks again, "And then it was that they got to see some of the bad stuff. The one camp had a car bomb. A suicide bomber drove his cab up into a crowd of people waiting outside trying to get work. That killed, I don't know, about 40 people, so they had a big Mass Cal [mass casualty] there. I was the sergeant in charge, and we had one

medic." He was there at the scene when the explosion occurred, doing medical screening for the Iraqi Army. "We were right there and two guys, our security guys, had pieces of flesh raining down on them. [The bomber] was actually trying to get inside but he didn't make it, so he got to the door and blew himself up there."

That, he says, was one of the bad ones. "Because I was the senior medic in charge there, and they sent reinforcements in, but there were people I…the families came quick. They were like, 'God, help me, help him.'" Half-living bodies and family members surrounded him, all begging for help. Brian says, "I couldn't waste time and equipment on this person when there's a person over here I can save. Their families are crying, crying and screaming, and you got to…just let 'em die. My junior medics - I gave them people [to work on], but a couple of them got there too late and just worked on the people who were going to die. My junior medic in particular, he worked on two people who both died. Because he got there late and everybody was working - everybody else was working somebody. I was going back and forth between three or four patients, and of course the doctor was issuing me the orders. Yeah. It was bad."

Of the stories Brian shared in our conversations, this was for him the most upsetting. The trauma was, in part, the ruptured bodies, the gore of flesh raining down from the sky. He admitted that he can no longer do emergency work. "It's the smell," he said. I thought as he said it that he looked vulnerable for the first time since I'd known him. He brushed away the moment, joking about having to smear Vicks' menthol beneath his nose to kill the smell, miming taking great gobs of ointment out of a jar and spreading it over his nose and upper lip.

Beyond the gore, the trauma lay in the families' loud cries of grief for those who – notwithstanding his skills as a medic – he couldn't save. It seemed also to be empathy for his junior medic, who was deeply affected by the two men who died under his care, insisting he

never wanted to work as a medic again. The difference between this story and his many others can be seen in the manner of the telling, his usually hearty voice slowing, the sentences strung together without jokes between. And the fact that, afterwards, he seemed relieved to move on to something else. To shake it off, wiping away the sounds and smells that lingered.

This difference can be seen, too, in how he tells another story, one he uses to explain his lingering trouble with driving in San Antonio (a common problem for recent veterans). By this time, he was back to his jokey self, notwithstanding the contrast between his laughter and what he had to say.

"And if I stop in traffic, oh my God. It just makes me batty. So…my kids laugh at me because I sit and scream in traffic because I can't take it." He chuckles. "Well that's when people got killed in Afghanistan. We watched when the Canadians who were a couple of vehicles in front of us…a suicide bomber jumped on the front of their car. And blew himself up and of course killed everyone in the vehicle. Now that happened, oh, 25 yards in front of us, and all we see is a guy, and Boom! And we're out of the vehicles, and we're running over trying to figure out what's going on. And the Germans – they have these huge armored trucks – and they saw it happen too and they were trying to see and they were literally rolling over vehicles to get over there. And when they got there, we had a crowd – I mean a crowd of Afghans, and these people were pushing towards the vehicles. And we're – that was tough…" He pauses for a moment, thinking, then chuckles again before diving back in.

"I was telling one of my buddies this story the other night…. I pulled a grenade out, and I pulled the pin out and held it up in the air like that, so all of them could see I had a grenade. And we kept telling them 'Za!', which means 'Get back! Get away!' And of course it's a bastardization of the word – we GIs make up our own words – but I was telling them 'Za! Za!'

You know, a couple of them were still pushing forward, yelling at us, and I threw the grenade. I threw it right in the middle of them. And when you pull the second one out, they all listen to you."

I was listening, too.

Brian does not flinch from most of these stories. He can speak of death in bursts bracketed by laughter. At the same time, he speaks with compassion of enemy combatants who may have been "conscripted off the street." He grieves for the families of those dead and lost, and mourns for those whose lives he could not save. His accounts are colored with lingering humor, pride, and grief. He is fully aware that these tales take on different qualities at different times, often to intended effect but with sometimes unlooked-for consequences. At the time when I first knew him, his teenage son was looking to join the Army. He told the boy, "You need to wait. Because whenever you hear me and [my friends] get together and we're all talking and laughing and drinking beer and giggling about stupid crap that happened while we were at war… You're only hearing the stupid crap. You're not hearing the sad and scary crap." In an effort to fix this imbalance, he took his son out to the truck one Sunday afternoon, out of earshot of the rest of the family, and they sat there for a long time. "I had to let him in on a lot of scary, crappy things. And I said 'You know, I've done things that I don't ever want you to have to do, ever.' And I did them because I didn't want you to have to do them. You know. I don't want you to have to enlist because I needed to enlist."

He is rueful as he tells me this, cognizant of the ironies embedded in such a conversation. *He* chose the military – he even thinks the military might be the right choice for his son, who is finishing high school and at loose ends about his future. But he joined the military in peacetime. War was an unexpected corollary for him, not something he planned on.

His son was talking about joining in 2007, when the U.S. was deeply imbedded in two wars, neither of which looked to have any end in sight. This was a different kind of decision. He admits that years of joking about combat mishaps around the backyard barbeque with his Army buddies may not have done much to dissuade his son from service. But he has a hard time telling the other kind of story, the sad and scary kind. It gets too overwhelming, he says, too much. "I can talk about it off-handed. Something like a little short story, I can do that all day. Which is pretty much the way veterans talk to each other about it. You don't ever get in-depth enough about it that it bothers you. Just a real quick, superficial, 'Hey, I remember when this guy did x, y, and z…' And they're usually funny. Not sad."

I remembered this description of how veterans tell their stories a few months later, sitting in a room full of soldiers on Ft. Sam Houston. I was there visiting a support program they have on-base for "Wounded Warriors," as they're called, those soldiers who have been wounded in the line of duty. At the time, the program was run out of a crowded suite of three open rooms, overflowing with sofas, boxes of donated gifts, computer terminals, and all the miscellaneous regalia of a social work service/lounge/bunkhouse. There were about a dozen soldiers in there, dressed in uniform, mostly standing around in a group and cracking jokes. None of them was obviously wounded. The performer of the bunch was a stocky guy in his physical fitness gear, shirt and shorts, who told a long story about taking his laptop into the repair shop to be cleaned out after three tours in Iraq. 'Where the hell have you been with this thing?' the repairman had asked, taking off the back-plate and pouring sand out on the table. 'Iraq,' he said, grinning. Another guy chimed in, 'Yeah, I go there for the summer,' and they all laughed. Somebody else broke in, 'For the fishing!' The guys got a kick out of that.

Funny. Not sad.

The Marine

Tony Sandoval was seven years old the first time he had a gun pulled on him. His father used to take him to a bar down by their house in a *barrio* on the South Side and they would hang out there, not arriving home until long after Tony's bedtime. He would sit at the bar and do his homework, watch TV while his father played pool, and swallow the soda and chips his father's friends bought for him. The fights would usually start later in the evening, when the men were drunk and Tony was getting tired, watching the TV over the bar with his head resting on his folded arms. Once in a while somebody would pull a gun, and this time – the time Tony remembers – the guy pulled the gun on Tony. The man was in an argument with his father and his friends, and pointing the gun at them didn't get the reaction he was hoping for. So he swung it around to where Tony was sitting, and held it on him until the bartender talked him into calming down. Tony thinks his father was so drunk that he doesn't even remember.

Home was not a lot better. Tony doesn't talk about his father beating him, although he is careful to say that his father never hit his sisters, a caveat he doesn't extend to himself. What he describes instead is those moments in the middle of the night when his father would come home and Tony would turn off the TV, run to his room, and wait, hardly breathing, to hear whether his father would wake up his mother in the next room. Sometimes he heard his father bellow for his mother to wake up and make him dinner. Sometimes he would hear the slap of his father's belt. There were times on the weekends when he wouldn't see his parents at all. His mother would be working, since his father wasn't good at keeping a job or at least at bringing home the check, and his father would be out somewhere. He might come home at 3 am and wake them up to eat the box of fried chicken or fish he had brought home. But in the meantime, Tony was left to look after his two younger sisters. His grandparents lived across the

street, so there was back-up in emergencies, but Tony remembers washing and peeling the potatoes to make French fries, then walking down the street to get a 2-liter bottle of soda so the kids could have a picnic in the living room. He still feels guilty, he says, for having been "mean" to his sisters when they wouldn't obey him. He says that the youngest girl, who he is still closest with now, shakes her head when he tells her this. "You were ten years old. If CPS [Texas' Department of Child Protective Services] had come by, they would have taken us out of that home."

Twenty years later, now a big-shouldered man with warm brown eyes, Tony still looks after his sisters. He is proud that he has never let them down, and that they come to him regularly for help – for money, for help in moving, to babysit his nieces. He is glad, too, that he can say about his siblings, "We're not statistics. We're doing pretty good." He prides himself on being a devoted uncle and a hard worker, on being a different man than his father and escaping the rough streets where he grew up. He and his friends used to joke when things got rough in Iraq, "How can I get killed here? I've been shot at in my own neighborhood. I'm not going to get shot out here." Having survived childhood, they'd laugh, how could war be any worse?

In making the decision to join up, Tony says that choosing to be a Marine was a "calling." "Growing up the way I did and being exposed to the things I was exposed to, [joining up] wasn't anything. I mean, it seems if like I can handle growing up the way I did, I can be a Marine." He says that his extended family was not universally in favor of his decision, and some people tried to discourage him: "'Like, why do you want to be a Marine? You think you're bad, or you think you're all that?'" He says his only response was, "I'm nothing yet. But I will be." He was determined to make something of himself.

He became a grunt, a Marine infantryman, and after a few years, a sergeant. He could not be more proud of his success in the service. I asked him once, after he had gone on about the Marine Corps for a while, "What does it mean to you to be a Marine?"

"It means everything to me," he said. "Literally, I think, it means everything to me."

He went on to say that, "Everybody in the service has their characteristics, their personalities. And I think the Marines have the strongest. You can be in a room full of soldiers, airmen, and there will be one Marine and everyone will be paying attention to the one Marine, because they want to know what he knows. They want to know what weapons he is using, what his job is. I guess the characteristics of my own – which is strong characteristics – were attracted to the Marines." He grinned. "I love the Marine Corps."

Tony was one of the first Marines to make it to Afghanistan after September 11th. He and his battalion were training in Australia when the attacks happened; they had just been released for 24 hours leave off the ship and had gone into town to make the most of the evening. It was around midnight over there on the other side of the world, the early morning of September the 12th, when his commander got the word that the Twin Towers had gone down and sounded the ship's sirens, broadcasting that all Navy personnel needed to report back to the ship. By 3 am, Tony and the rest of his company were back on board and standing in formation on deck; his commander announced the news. By 6 am, the aircraft carrier and two submarines were on their way to the Arabian Sea. It took them two weeks to get there, and then they set up base in Pakistan before moving into Afghanistan, where they spent the next four months.

I asked him what that deployment was like, so early in the post-9/11 world. "A lot of patrols. Freezing cold. Our company got to go up to Kandahar, and all we had to do was

surveillance. A lot of civilians killing each other." He shrugs. "It was kind of boring because everything was already done. We went on patrols every day looking for somebody, looking for Osama Bin Laden. We saw [the Taliban] a lot – if we saw their trucks we'd just bomb them. We'd call in orders – 'We've got trucks down here, about 2000 meters' – and we'd send bombs down on them. Then of course, later on, we'll send a battle damage analysis group down there and if there are any survivors, we'll bring them back for interrogation. And we'll bury their vehicles. Afghanistan wasn't too bad. Well, for me. I didn't see too much. It wasn't real stressful. We could sleep."

Tony doesn't muster up much energy talking about Afghanistan. It wasn't that big a deal for him. He gets much more worked up talking about what happened right after he got back to Camp Pendleton, when the battalion was gathered together for a final set of workshops before a three day leave. Someone up the chain of command decided that the best way to bring the battalion together as a unit – all five companies, some 1500 Marines – would be to have them run three miles, separated by company and singing cadence all the way.

"So we're doing this run… And we have our flag and we take turns carrying it. And [our Sergeant]'s like, 'We're Bravo – and we're the best! I don't care about Alpha and I don't care about Charlie.'" In other words (and probably working against the kind of battalion cohesiveness the command had in mind), the sergeant loudly celebrated company loyalty over all. A Marine from one of the other companies ran to the man carrying Bravo's flag and tapped him on the shoulder. Tony was watching and saw the flag-bearer pass the flag to the new guy. For a minute he thought maybe the new guy was just somebody who had recently transferred in to the company, but then the guy took off running and he realized that their flag had been stolen by someone from another company: "And two guys and me, we're like 'Let's go!'" He

and his friends ran down the thief and Tony jumped him and threw him down to the ground. "I got on top of him and I was like, 'Don't *ever* do that!'" Tony's face lights up as he is telling me this; he is leaning so far forward he looks about to jump up out of his chair. The rest of the company saw what happened and quickly hailed him as a hero. "And everybody in my company's going crazy yelling and it was so intense. And they let me sing cadence and I'm like," he starts singing, loud and proud, "Corporal Sandoval come on out! Let me hear you scream and shout!' And I run out there and we're yelling and the battalion circles around us and everybody's 'Ahhhh!' And it was intense!"

He finishes the story and glances back at me, eyes bright. He looks like a retired football player watching his own highlight reel of touchdowns and impossible intercepts. This one instant seems to crystallize everything he loves about the Marines – the camaraderie, the competition, the physical challenge, the chance to be the very best. It's all there.

He tried to leave the Marines shortly after this. He had fulfilled his active duty contract and went ahead and separated from service, planning to move on with his life and spend more time with his family. He took it easy for a while, not working, living off his deployment savings, but it didn't take. He was bored. He says that he walked into the recruiter's office many times, but couldn't make the decision to go active again. His mother was against the idea. So he compromised – he joined the Marine Reserves. He says, "It was fun. I got to train, to teach other Marines. It was cool because I brought active duty with me." He was unpopular with the other Reservists because he pushed them constantly to live up to the same standards as an active duty unit. "They hated it. Because they think you can do it just for that one weekend and that's it. But no! You have do it the whole 30 days – every day of your life. You have to be able to do a PFT [physical fitness test] at a moment's notice."

He got the call to go to Iraq in late summer 2004. The U.S. had invaded the year before, and Tony, as a post-active duty reservist, had the option not to go, but it wasn't even a question for him. "I'd been training these reservists for what, a year and a half? I could not NOT go. It's not possible… You train with these Marines and you can't abandon them. You're a Marine and you're a squadron leader and it's your job." He says, though, that he cried when he had to tell his youngest sister he was leaving. She cried and cried and cried. "I was like, 'Don't worry. I'm going to Iraq with a bunch of Marines just like me! She was like, 'Ok.' It was like that made her more comfortable, that there were other guys there just like me, that were taking care of me." He told her, "There are people who don't get to come home, but they're looking over us. They're watching over us like guardian angels."

Once in Iraq, his conflicts with the other reservists settled down. His squadron came to realize that his combat experience meant something, and that his efforts to push them had made them better prepared for the work they had to do. They began to trust him. In return, he says, "My concern the whole time was, first, my Marines. Were they getting enough sleep? Were they getting fed? A lot of them were having marital problems. A lot of them. Girlfriends, wives cheating on them. Things you just couldn't do nothing about. I knew that. I already knew that, being in for so long. So I just tried to help them out, tried to get them through." Without pausing, he went on. "It's scary when you hear mortars landing. Boom. Boom. Everybody stops – how far is it away? Where's it at?" I thought it was interesting how he moved – in the space between one sentence and another – from cheating wives to falling mortars, as though these things were perhaps not so different, both just potential threats to his men.

It wasn't long before knowledge of Tony's experience in Afghanistan got around and he was transferred to a unit closer to Fallujah. He hated being taken away from his unit, although

he knew trouble was brewing. The first battle in Fallujah had been the previous spring, after Iraqis captured four American contractors, burned their bodies, and hung them from a bridge. The Marines had gone in then and, as Tony describes it, put a cordon around the city. "No coalition troops went in there, nothing. So we knew we were going to have to go in there eventually. It didn't take a rocket scientist to figure that out."

"So…in late October we did what's called a feint, where we went to the south side of the city and just kind of did a probe, you know, a small little quick battle where we just pushed in real quick and fought for a few minutes and backed off. Just to test their defenses and see how well defended it was." There were no casualties then, no wounded. But by early November, momentum was growing for a larger onslaught. "All the ammunition started to come in. I mean piles and piles and piles, just massive amounts. And all the commanding generals were coming by, and they were talking to us, and we all knew it was going to be a big battle. It was going to be big and somewhat historic as far as Iraq went. But the commanders and generals, everybody was building it to be … we were going to live in history books and they were going to mention us in the same breath as Kai San and the Cho-Sun Reservoir and Iwo Jima, and so it really started hitting home to all of us, all of the Marines."

On November 9th, Tony's new unit moved into position. He was given the job of coordinating between his infantry unit and an artillery team, calling the artillery forces for back-up whenever his own group got into something bigger than they could handle alone. They began the push through the city and for the next several weeks, the battle was his whole world. He thinks the first time he actually got out of the city was December 15th. "So it was 35, 40 days, something like that, without a shower, just eating MREs [Meals Ready to Eat] and stuff like that. I got to sleep in a bed, on a bunk, instead of on concrete and stuff. That was nice. I shaved all

my hair off because I didn't want to wash it." He laughs. It was a short reprieve, and he went back into the city in the morning.

His battalion, he says, had a reputation for "showing no mercy." "When we would go through houses, we would burn them down. The ones that were stone and stuff like that, we'd bring bulldozers and bulldoze them. You could look at satellite images of Fallujah now and there's a road that runs north and south and everything between that and the river was ours and it is flat. We just flattened it. Because the enemy… we would push south and the enemy would move back and around and would try to rebuild behind us and flank us and do all that. So…we dropped bombs on it, and whatever didn't flatten we bulldozed or did whatever we had to do."

There was a sudden shift in his tone as he said, "Saw lots of dead people, lots of bodies. Enemy and friendly. Saw lots of wounded Marines. Marines get killed. So… been there. Seen it all." He fell silent.

I was struck by how he ended his story of Fallujah. He had spent a long time telling me about the build-up to the offensive, the artillery used, the tactics for preventing "the enemy" from moving back into areas that had already been occupied, summoning the long-winded detail of the expert. And then, in a series of fragmented phrases at the end, he touched so superficially on this other part of the story: the carnage he witnessed, the death, the consequences of all the military muster. His extended narrative drifted apart in a string of words, and I found myself thinking about all that was left unsaid.

He admits that he prefers not to talk about that part of his time in Iraq. The second time we spoke, he told me about a new guy at work who was a former Marine; he cornered Tony during break one day and started asking about Iraq. Tony thought he wanted to test him,

to see whether he was really in combat, as many veterans will when sussing each other out. When the new guy found out that Tony had been at Fallujah in '04, he shook his head in acknowledgement: "Y'all had it rough out there." As Tony looked on uncomfortably, the guy went on, "You lost a lot of dogs out there. Y'all got into a lot of shit." Tony replied, "Yup, and that's how it was for me the whole time." Then he shut down the conversation and walked away, hiding the tears in his eyes.

Reflecting back on his time in Iraq, he says, "We took it - my guys and I and everyone we were with took it as second nature. It was just our life, we had to survive. Do what we had to do, you know what I'm saying." But the encounter at work opened up something in Tony. "He stirred up some emotion, and I was just like, 'I don't want to talk about it.' And then some other guys were like, you know, in shock, because they don't know anything and I've been working with them for three years. And this guy comes up and opens his big mouth and starts spreading the word of what I've been through."

Tony, like Brian, is a talker, chatty and articulate. There are plenty of things he is happy to talk about – boredom in Afghanistan, his love of being a Marine, ground offensives in Fallujah, even, although cautiously, growing up with an alcoholic father. But the consequences of war, the bodies of his Marines, this was ground he wasn't ready to venture onto, and, in some vague way, he resented being pushed into it. When I thought about it later, I realized the problem. He had chosen to keep silent about those experiences, and the new guy didn't show proper respect for that silence. It wasn't the new guy's story to tell.

The Witness

Jesse Caldera looks like a lot of veterans who have been home a few years, with his service-time leanness replaced by some extra weight. Many veterans pick up a few pounds in the early years after they get out of the service, a predictable result of the usual decline in physical activity once PT is no longer mandatory. The change in Jesse's life lingers around his belly and jawline, softening the lines of his face under his hazel eyes and dark hair. He is an anxious man, shifting constantly in his seat, never quite at ease. Sometimes when he talks his eyes seem very far away, taking on the "thousand yard stare" so commonly described on the faces of combat veterans who have seen too much. Other times - when he becomes a little agitated - he talks a mile a minute, rushing nervously over a river of words. He grew up in San Antonio, the son of a Mexican-American father and a German-American mother, although he says he was "raised Mexican." His father served out his career in the military and so Jesse followed in his footsteps when he came of age, signing up for the Air Force at the age of 18, in 1999.

He loved the military and the friends he made there. "I loved the fact that I was just – it felt like a family. All these people I didn't even know, but we loved each other. There were a couple of guys – we went through basic together, then school together – it was like watching each other grow up. And then when we went to Iraq it was difficult because we were with different detachments. We would run into each other but then it was like, 'See you when I see you. See you when we get out of here.' It was hard, it was like a part of me had gone with them."

He was sent to Kuwait in the early stages of the U.S.'s preparation for war. First posted to an airbase there, which he said was like "Candyland" because there was no threat of attack,

he remembers the start of combat operations in March ’03. He watched the overhead flight of Tomahawk missiles heading north from the airbase to rain Shock and Awe down on Baghdad. He got settled into his work loading and unloading aircraft at the base, and it was there that he encountered the first consequences of war.

“We started having bodies coming in. That was the first time I saw *that*. I dealt with HR – human remains – moving the bodies into the plane. I didn’t think about it much, but it made me sad.” He starts to change the subject, to begin talking about the convoys he began accompanying later on, but returns quickly to the remains, his face becoming more animated as he strings the sentences together. “A lot of bodies. A lot of bodies. And that really made me sick.” In the course of his duty at the airbase, he ran into many of the soldiers and Marines and Special Forces operatives who were on their way north to Iraq. He would have just enough time to learn a new acquaintance’s name and face and attitude before the guy would go up across the border, and then, he says, “A few weeks later he’d be in a box. You’d be cussing him out, ‘Fuck you, you Marine!’ Just playing around, and then you’d read in the newspaper that they’re dead. And you’re carrying the bodies, carrying the boxes. You think about their families, and it was just really sad. And a lot of them at the time were younger than me. Life’s just starting off and they’re dead. There were so many of them it was hard to comprehend. Then they started coming out in bags, and you could see the perfect outline of their bodies, and that just made it more real.”

Jesse stayed on HR duty at the Kuwaiti airbase for a while, before one of his friends, who was working transport, told him that they had a shortage of people working out of the Baghdad airport. He talked to his commander and got permission to work on convoys going between the two airbases. He says, “I don’t know why I did that, but this guy was the only guy

on the whole base that I knew. So I volunteered to go and we went to Baghdad airport when it was still Saddam Hussein Airport. It was weird as shit. I was scared…real scared. But I ended up doing a lot of [convoys] with him." It was a strange experience. "You never knew if somebody was going to try and shoot at you…seeing the little kids…it was awkward. The little kids would try to sell you ice. They'd have soldiers' uniforms on…we used to have candy and we'd throw it away from the truck so they wouldn't come near the trucks and get… It was weird." He seems stymied by how to explain it all – the children he saw while running convoys, his discomfort at being dressed in unfamiliar Kevlar and carrying a borrowed rifle, only issued to him for the duration of the convoy since his day-to-day work didn't require the combat gear. He repeats himself often, face bemused, describing these experiences as "weird" or "awkward."

He found himself in ever odder territory, farther and farther away from the Kuwaiti airbase to which he was originally assigned. Six months into his first deployment, he got stranded for a week in an isolated Army outpost, having delivered a supply load from Baghdad as part of an Air Force transport team. There wasn't enough food or water there at the time, so showers were in short supply and tempers were short. They did have electricity, though, so he holed up with some Army guys he met during his off-duty time, watching TV and DVDs and listening to music.

The soldiers described their unit as one that had been functioning well until they arrived at the new camp, which was housed in an old Iraqi prison. They had found the place still filthy with blood and feces, with bodies hanging in an area they figured had served as a torture chamber. They cleaned it up, only to find they were there without a steady supply stream and no clear orders for what to do next. At that point, they told Jesse, "The attitude changed and everybody was like, 'Do it your fucking self.' People just getting to be real aggressive with

themselves and everyone else. People were passing out from dehydration and there was a stomach virus going around. You're talking about bad." Jesse woke up one morning and climbed outside the tent to find a cluster of soldiers watching a Sergeant use an air compressor to blow sand off an area to the east of camp. There was nothing visible beneath the sand except more sand – no concrete slab to uncover or equipment buried there. It was just an open space of desert, with the Sergeant standing there blowing away layer after layer of sand. Jesse laughs, remembering. "It freaked everybody out. We were all looking at him like he's lost his mind. But there he is with rank." He noticed that there was a lot of conflict between officers and enlisted at the outpost. Regulations were inconsistently enforced, with proper dress and salutes required some days and ignored others. The more disgruntled soldiers were getting into trouble, copping an attitude like, "I'm in Iraq, what the fuck are you going to do? You going to shoot me? Go for it. Send me home!" Stranded in the middle of a desert with daytime temperatures hitting 130 degrees, with short supplies and officers standing around blowing sand into nowhere, Jesse began to understand how getting shot might look like a decent alternative.

He was nearing the end of his first deployment himself, and didn't need any convincing that it was time to go home. A few weeks after he got back to Kuwait, he was shipped back to the States and spent the next six months back at Lackland Air Force Base in San Antonio. He received orders to deploy again, this time to a base within the hotly contested area known as the Sunni Triangle. They landed first in Kuwait and he settled in for a few days of waiting for a flight north, drinking beer all night with a rowdy group of coalition forces – Australians, Lithuanians, Latvians, and Estonians. Midway through the party, his sergeant came to find him, announcing that they were taking an early flight out to the next stop. As he got on the plane, a

little drunk, he was feeling sick and out of it, so it took him a minute to process that everybody else in the plane was sitting on their helmets, something he hadn't seen before. He describes the next period of time as leaving him "pretty fucked up." As he describes the flight and the days to come, his story falls apart, becoming scattered and confused.

"So I was sick, and then I saw everybody sitting on their helmets…why is everybody sitting on their helmets? So then everybody's coming out and telling us we're doing a combat landing and I was sick. And we were escorted….couldn't go anywhere in the town without body armor. I was thinking 'What have we gotten ourselves into?'" He begins describing the town where they landed, focusing on the only things that mattered at the time. "A guy had gone into the town the week before and gotten himself blown up - lost all of his appendages except for one arm, but he ended up living. Nobody knew where we were supposed to go, so we were all over the base. We got to see the POWs and the Iraqi prisoners in the orange jumpsuits." He continues without a break, a little breathless, "And they started mortaring us, and I heard these sounds…we were running with this Colonel…I'd been on the phone with my Mom when they started mortaring us. I had to get off the phone and she was crying…running with this guy and hiding behind this concrete wall. We didn't have our body armor so [the Colonel] gave us his, and we were like, 'Who is this guy?' He was one of the commanders, but we were like 'Holy shit!' And they were firing on the runway, and the radio was blaring, and I remember that after one hit I couldn't remember for a few seconds what had happened. I was dazed and confused. They kept mortaring us, and we called it 'Mortaritaville.'"

He stayed at this base for a few days, long enough to begin sleeping with Kevlar slung over his body in case they were bombed at night. Long enough to remember watching a string of football games that were interrupted by mortar attacks. He remembers wondering, "Why the

hell are we out here?," and describes feeling caught in some strange recycling of events: Mortar, sleep, waking, work, mortar, sleep, waking… "It was like the same old thing, it just kept re-occurring."

Somewhere in the midst of all this – the football games on TV, the phone call interrupted by mortars with his mother in tears on the other end, the flight across base under fire in body armor handed over by an unknown Colonel, the post-attack jokes about "Wasting Away in Mortaritaville" – he and his sergeant sat down to write up a transport plan, having found themselves a spare corner in the intelligence office on base. The intelligence section was monitoring the radio at the time, and they overheard a call coming in from a squad on patrol in the city. The squad's gunner had been wounded and they were calling back for a medical evacuation, requesting a helicopter to come and pick up the soldier. Jesse ticks off the minutes in this overheard tragedy, which went on for more than an hour. He remembers the voice of the squad's communications guy coming over the radio: "Please come. Please come, this guy is bleeding to death." The command back at base answered quickly, reassuringly, telling the squad over and over to stay in place. "A helicopter is on its way."

But as Jesse tells it, "A helicopter is never on its way. So finally about an hour passes and [the squad is] like, 'We can't wait anymore, we have to get to someplace.'" The squad decides to drive to a medical facility about 15 minutes drive from where they were hit. They don't make it in time; the wounded soldier dies along the way. In Jesse's calculation, the soldier would have survived if the squad had just driven for help in the first place without waiting for the helicopter promised by the command. "He probably would have lived. And you hear that whole thing transpire on the radio. And the guys in the command are saying, 'The pilots are on the tarmac right now. They're walking towards the verge. The helicopters are going to leave in

just a few minutes.' And that satisfied the guys on the other end, but all it was was a lie. And it's very apparent at the end when the helicopter never shows up."

I asked him why the command lied, but he says he doesn't know. No more than he knew why the sergeant would stand on the edge of a desert blowing sand into the wind, or why an unknown Colonel would hand over his body armor in the middle of a mortar attack. His whole experience of Iraq seems to be one of wandering across a surreal landscape, passing from one inexplicable event to the next without any sense of order or reason. As a low-ranking Airman (First Class), Jesse lacked access to the kind of intelligence or operational information that might have given him a broader view of what was happening around him. As someone who served as support personnel, for the most part, rather than as an officer or technician or active combatant, his version of Iraq lacks the expert's sense of a job well done that oftentimes organizes tales like Brian's and Tony's.

After the Sunni Triangle, he returned to Kuwait, where he went back to running the occasional convoy as a break from his loading job at the airbase. He shakes his head and concludes about the convoys, "It wasn't part of my job to do that, but I guess I'm glad I did, because it needed to be done." Loading human remains remained part of his job, and at a certain point, he was also assigned the transport of wounded soldiers and Marines, some with bullet wounds, some with limbs shredded by explosives. "You'd be carrying them and be like, 'Fuck!' You'd look at them and be like, 'I don't know, it looks like he's gonna die.' It was really awkward."

There was something about the way he said this word, 'Awkward,' that struck me. Perhaps it was the at-times panicked look in his eyes as he spoke, but somehow that single word communicated what a more articulate phrase might not have. In contrast to the parts of his

deployments that he speaks openly and freely about – laughing with drunk Australians in Kuwait comes to mind – there are other parts where his narrative falls apart entirely, days and events swimming together, and where he seems at a loss to describe his feelings except as 'weird' or 'awkward.' These are general words, usually applied to small events in daily life, small abnormalities in the fabric of the universe: "I had an awkward moment at the meeting today…" or "That man we met last night seemed a little weird." They seem odd when put to the shattered body of a fellow service member, or to the act of tossing candy for Iraqi children from the convoy trucks rolling through their villages.

Late in our interview, the "weirdness" of the children he described earlier became a little clearer. In response to a question about why he doesn't like to talk about Iraq, he said suddenly, "I think I killed a little kid when I was over there." His next few lines became jumbled, as he veered back and forth between explaining how he doesn't like to talk about it to explaining why it was unavoidable: "They told us not to stop. I think I only told my brother-in-law when I got drunk when I go back. Oh God. He reminded me of my niece and my nephew. He told me, 'What were you going to do? It was either them or you…If you woulda stopped...' Because what they would do - let me tell you this real quick - they'd stop us, then shoot a rocket until we started a sniper attack. They'd have a lot of little kids running around the truck…" And then he veered off again, referring to a movie that reminded him of Iraq and then a dinner he had eaten in the palace of a Kuwaiti millionaire.

Over the intervening months since we talked last, Jesse's descriptions have hung with me in a way that other veterans' more elegant phrases have not. This is, I think, partly because his inability to speak more eloquently about what horrified him points once again to the problem of what is left unspoken in war stories – those silences that also reverberate

throughout Brian's and Tony's accounts. But there is more to these words than simply the jagged ellipses they glide over. There is also the way in which Jesse comes back to them over and over again, picking away at the wounds they cover because they have not healed. He is not at peace with these memories; they seem to clutch at him. He says he has frequent panic attacks where he begins hyperventilating, unable to breathe. It is like the sum total of what he witnessed in Iraq - the surreal, the wasteful, and the tragic – has somehow caught in his throat.

The Wounded

Derek and Laticia came into the hospital together to meet with me. He is tall, well above 6 feet, in his late twenties, and walks in wearing baggy shorts and a titanium prosthesis where his left leg should be. His skin is very light – there are hints of both his African-American father and white mother in the shape of his features and sharp green eyes. Laticia, by contrast, is quite dark, her skin and hair highlighted by the gold necklace and bright pink shirt she wears. She has a delicately shaped mouth and one of those subtly pretty faces that becomes more beautiful the longer she speaks. She let loose with a powerful laugh a few times during our talk, but for the most part spoke with a quiet tone, clear-eyed and focused.

Derek grew up in the Pacific Northwest, raised by his mother's family after his father, himself a medevac helicopter pilot in Vietnam, disappeared from his life when he was a child. He joined the Army in 1998 and thrived there, studying communications and moving steadily up the enlisted ranks. He was introduced to Laticia in 2004 by a mutual friend when he was posted to Ft. Bliss, out in El Paso. They were a long-distance couple from the start, since she was working on a Bachelor's degree at Texas State and taking care of her two children from a previous marriage, and he kept getting sent around the country for trainings in the run-up to his

deployment to Iraq. But they spoke every time they could, and brag proudly that their longest conversation in those early days stretched for nearly 10 hours. They say they both knew from the beginning that this was it.

When it came time for Derek to deploy to Iraq in mid-2005, Laticia was there to kiss him and send him off. "We didn't get married because we didn't want to get married just because he was deploying," she explains. "I wanted to finish my degree under my maiden name so my Daddy would be proud and my Mama would be proud." After they said goodbye, she drove back to San Marcos and threw herself into her coursework and caring for her sons.

Meanwhile, Derek was moved out of the communications unit he had been serving with and re-assigned to a patrol unit in Baghdad, much to his disgust at what felt like a waste of his training. "Things started blowing up, people started getting hurt, and I was like, 'Anybody can do this.' We were pulling security, going out on trucks, and I was like, 'Send me back to where - I don't know if I can keep these people alive or not, but at least I'll be participating. I'll be helping out in some way.'" After seven years of training as a communications analyst, he was overwhelmed with frustration at being unable to use his skills to protect the men and women around him. Looking back, he thinks that frustration probably fed into a "very very mild depression."

Within a few weeks, however, he was patrolling nonstop. He and his new unit were, "Constantly busy. Constantly busy. Constantly. When we first started there, we started running night patrols and stuff. Day and night patrols. We were working 72 hours straight. Just constant go go go go. And we were able to work, able to do it because we were so pumped with adrenaline because so much was going on."

After a while of living like this, he found it was difficult to remember anything else. "We

felt like we were these time-keepers. We could control time and space and whatever. But then you're trained to believe that you're like a machine. You're unstoppable. And it was good and bad in a way. It was good because that's what will keep you going - that's what will keep you doing your job as well as you did it. But it was bad because whenever something did go wrong *you* would be blamed for it, not anyone else but yourself. And that would mess with a lot of people, it messes with a person's head a lot."

Things began to go wrong, as they will in a war zone. Little things, at first, like a mission that didn't go as planned or someone getting injured in a training accident. His unit was posted adjacent to Sadr City, then the most dangerous area in Baghdad, and even minor problems reminded them how high the stakes were. "You wouldn't think so, but being where you're at and knowing what you know, it puts a lot of unnecessary questions – a lot of doubt – in your mind. You start doubting yourself. You start doubting the military – what are we doing here? – after a while. You start doubting your support at home, after a while, like no one cared about us."

He lingers on this sense of uncertainty and isolation. "It's like a whole new, whole different world. Being in a third world country like that is just so different - it's like going to a whole new planet." He came to a point where he began to embrace the disconnection, where he found himself making an effort to forget his fiancée and family while on duty. "And that was the only thing that kept me from getting killed, or letting somebody else get hurt or killed. Because if you're constantly thinking about home home home…." He shakes his head and his voice gets harder here. "If you saw somebody and they were down and they mentioned something about home or family or something like that, we wouldn't take them [out on patrol]. We wouldn't take them with us. It's a simple fact, because that's the person that might get you

killed. They'd be like, 'I'm alright, I'm alright.' And we'd be like 'Unh-unh,' and take somebody else."

I looked over at Laticia as he said this, and saw that she was nodding, focused on him. I spoke up to ask Derek: "What would you say to them? What would you do?"

"'Just relax and just take it easy for tonight or today. Tomorrow if you feel better we'll go ahead and take you. We'll try to take you to a phone so you can call back home.' Which is the right thing but at the same time the wrong thing to do. Yeah you want them to call home and let his family - or her - reassure that soldier that everything's okay. But what if it's not and that just makes the situation worse? So being a supervisor was kinda tough because you had to make those decisions… There's a lot of decisions that you're faced with that were not easy at all. None of the actions that we took were easy. Not a single one, the whole time we were there."

Meanwhile, Laticia was back in Texas, taking 20 credit hours a semester in an attempt to rush through the remainder of her degree. "I just wanted to get it finished. I had it planned so if I needed to pack up and go to Tennessee and be an Army wife the real way, that part of my business was already taken care of. And he told me," she pauses, swallowing, "that he was safe, in an office, doing communications type stuff, so my mind wasn't thinking, you know, about what he actually was doing. I didn't see him as in danger. I guess in my mind I was thinking he's in this thick underground building, milling away." They kept up their habit of talking often. "None of the emails were strange," she reflects. "A couple of the phone calls were strange."

"How so?" I asked.

"They were, 'Oh, I love you. I love you so much.' They'd just be kinda solemn. I'd be like, 'What's wrong? What's wrong?' And he'd be, 'I really just want you to know that I care about you.'" She was at a loss, sometimes. "I don't know what the Army is, I have no idea what

Iraq is like, I'm gonna just be supportive. Whatever you need. You need just to breathe on the phone and pray with me, whatever. There was a couple of conversations like that. Of course I didn't know what was going on. And then we'd email, and sometimes the emails would get in depth." She compared the tone of those emails to talking with a family member who is dying. "You know how they go over how much they love you, how much they're going to miss you? It kinda felt like that - a couple of the emails, a couple of the phone calls. But I didn't know what was going on. So I would just be there supportive and back him up." Hearing from her cousin at Ft. Hood about infidelity among spouses and girlfriends back home, she made sure to let him know, "I'm on the straight and narrow. I'm doing what I need to do. I've got my nose in a book. So just come back! Come back!"

On his end, things were heating up, explaining the solemn calls. They started running into explosives, snipers, and mortars at periodic intervals; Derek counts off a string of holiday attacks. "Halloween we got hit. Thanksgiving we got hit. And then Christmas Eve was probably the first major phone call to her like that. We got hit coming in. We were ok. We got back to base and a little while later we got a phone call that - there was another truck out, in the same city, got hit with an RPG [Rocket-Propelled Grenade]. And it was this weird freak occurrence because somebody shot an RPG, it skipped off the ground, stayed intact, and it hit between the wheel … It went under the truck, bounced off the top of the tire and went straight through this girl, was sticking through her armor and everything. And that one took me a while to deal with and get over because she was 20 or 21. She had just got there a few weeks before, and she was the sweetest girl you could ever imagine. She was an interrogator. She didn't like her job because she had to lie to people, and she wanted to get out of the Army. The sweetest girl you could meet, and on Christmas Eve, an RPG comes through her. So that one rattled me a lot.

Especially because I was there in the same part of our compound, for our section, and I spent a lot of time with them. So they became my quasi-soldiers. That was like one of my own."

"And that one still hurts. But I realized then, I think, that if a freak accident like that can happen on Christmas Eve to the sweetest person on the entire FOB, then it's anytime. So that was one of the phone calls [Laticia] got. And then my grandfather's birthday was January 18th, and one of my best friends - he was also a THT guy - uh, Tactical Human Teams. Once again, they got hit with an RPG, and we'd been briefed for a week and a half that there's always IEDs [Improvised Explosive Devices] in the afternoon at a certain checkpoint. We've known this. 10 days in a row. Find a different way around it." The advice was ignored by the higher-ups. The first team – Derek's team – made it through that checkpoint, only to be hit by the detonation of a dump truck on the other side. No one was wounded, although Derek's truck was torn up by the blast.

"After we had gotten back, we had just taken everything off, parked the trucks, filled them up, taken the guns off and sat down to play dominos. And there was just this huge explosion. We could see the smoke from where we were in the town, and it looked like it was from the checkpoint we had just come through. Scott, who was a real good friend of mine, was the THT guy in the truck, and it looked like their truck had been picked up, turned on itself, and the whole truck was just crushed. Killed everyone in the truck. On top of being my grandfather's birthday and he was not in the best of health, I get blown up, and then a good friend of mine who - we had a lot of similarities, he was like a younger version of me - that one hurt the worst. And I know I called her that day." Laticia nods, remembering.

After this, he says he stopped doing "anything." He stopped smiling. He stopped eating and sleeping. He stopped caring about anything. He began counting the days until he made it

back home. In the meantime, he stayed in his position, going out into the city every day. They got hit on Valentine's Day, and then the string of bad-luck holidays seemed to break. His birthday passed without incident, and he began to relax. There were good times amid the rest of it, sitting around playing dominoes or drinking tea with Iraqi leaders, chasing donkeys. "You can imagine all 6 feet of me on one of those donkeys."

One day, working with the Iraqi police, Derek and his team accompanied a group of Kurds going to arrest a Sunni leader, an unpopular arrangement in the increasingly divided nation. "Suddenly all these guys showed up." He says it was like a "Western style standoff." "We were all playing dominos, sitting in the trucks, waiting for this guy to come out in handcuffs. And then these guys show up, so we all load our weapons. So they load their weapons. We put on our armor, and they started putting their vehicles in little strategic places, so we get in our vehicles and load the big weapons. And then the Kurds are pointing their weapons at the Sunnis, and it was one of those moments where it was real tense at the time and on the way back we laughed the whole way. Because it was comical." Listening to him, I got the sense that certain stories began to seem hilarious just by virtue of having a happy ending.

He made it to April before his luck ran out. He and his team were escorting an Iraqi politician through the city, and stopped in front of an all-Iraqi police checkpoint. "Three days earlier the snipers had shot one of the Iraqi policemen because he was putting an IED on the side of the road in police uniform. Same spot. I talked to my vehicle commander and I said, 'Sir, of all of the places to stop in this country? You don't stop for 15 minutes in front of this checkpoint and then drive through it, because they're going to radio ahead and something bad is going to happen.' And he said, 'I know, I talked to the Major. The Major says we're stopping

here. I'm with you, but there's nothing I can do about it. So we're stopping here.'" They took the precaution of staggering the American and Iraqi trucks, with an Iraqi vehicle between each two American ones, and they went on through the checkpoint.

He is succinct. "Two explosions. One on the front of my truck, one on the back, and my foot is hot."

"It's in pain, and it's wet, and that's all I knew at that point. There's gunfire everywhere. And I'm a 50 Cal gunner, so I'm up on my gun, just spraying everywhere, because I don't know what's going on, I can't stand up, I can't see. The medic - and I blacked out, so I didn't know what happened until they told me later - my medic was frantically beating on my window, trying to get me to wake up. Because we have the combat locks on the door so nobody can get in, so he's just frantically beating on his window trying to get in the window. And my first thought, and this is as soon as I wake up, as clear as anything, was 'Why is this crazy medic beating on my window in the middle of a gunfight? What is he doing?' And he's trying to get to me. But I open the door and he comes in and puts a tourniquet on me, checks me from head to toe, checks everybody else in the vehicle, calls in a medevac. We got our vehicle back the 4 kilometers to base, and then at some point I had had 4 morphine injections and I was completely stripped naked under some shiny metal blanket on the helicopter, flying through Iraq."

"I remember the helicopter landing - I remember going through some weird place - I remember waking up. And one of the Army nurses was like, 'You're going to be okay. They had to amputate your leg.' I was like, 'Ok.' Because I had seen - when the shrapnel came through my foot, my foot was hanging this way, and if the boot hadn't been there it would have fallen apart. As soon as they put the tourniquet on, I knew I was losing the foot." He was pumped full

of narcotics, and is still not sure how long it was before he realized he had to call Laticia. "I knew they were going to have my unit notified, they'd have my mom notified, but I knew nobody was going to call [Laticia]. I was like – I need to call my fiancée. That's rule 1. I'm not going anywhere, I'm not getting on a helicopter or anything until I talk to her. So they give me a wheelchair …." He inserts a joke: "Try to figure out how to use a wheelchair when you're really really loopy." He grins. "I tried to stand up and every time I tried to stand up I fell over. So I called her."

Laticia remembers the phone call better than he does. "One of my friends - she was staying with me, because she was going through some stuff. We were watching a movie that night, and the movie was *Jarhead*. I was like, 'I can't watch this! My baby's in Iraq. This is too much.' So I went to bed, and that night I get a phone call. He was kinda foggy, disoriented. He said, 'I got some good news and some bad news. I'll give you the good news - I'm coming home early!" I'm like, 'WHY?' All I wanted to know was 'Why?' And all I heard was, 'We got hit.'

"And then I couldn't hear anything. And then I heard 'amputate' - oh my God! What's going on? I heard, 'I'm fine…blah blah blah blah I love you blah blah blah blah blah I gotta go, they're wheeling me… Blah blah blah blah blah.' And that's all I heard. And since I'm not married to him, I don't get any information at all. So I was like, I'm going to call his mother. So I called his mother in the middle of the night and told her and she was able to get all the information from the formal side. And I called friends – he'd left me all their numbers – and got all the information on the internal side. And then we just mixed all the information together until he was able to call me back five days later."

Derek reaches for her hand and says, "They shouldn't let people use phones when they're on heavy narcotics."

Laticia shakes her head. "I will never forget that night. Never."

In talking of Iraq, Derek ends by saying, "One of the things we study is weapons and how weapon systems work. Grenades are an area weapon – they detonate and spray shrapnel everywhere in the area. That's what they're designed for. The grenade that came through the truck, all of it came through in one chunk and was embedded in my foot. I had my foot up on the rail like this, so I could move my trigger because my trigger was heavy. Had my foot been an inch here, an inch there, all that shrapnel would have come through, spread out, and because of the way I was sitting – I wouldn't even be sitting here. And then the two guys behind me – it probably would have gotten them right in the neck. So the way I see it, I traded my leg for all three of us in the truck. So that alone really helped me deal with it, and my attitude, and I was home and other than missing a leg, I was pretty much intact."

I noticed a contrast between this last story and the others he had told, whether about his frustrations with the command structure, his grief over the deaths of his friends, or the explosion that claimed his foot. Listening to the recording of our conversation later on, I realized that this last anecdote represented a different kind of war story altogether. This was a story, not about describing an experience in an effort to share it with others, but instead about making meaning out of the injury he had suffered. This story offered an equation – one leg for three lives – that added up to Derek's way of justifying the loss.

His injury was the beginning of a long journey for them both, beginning with his flight to Germany and then Walter Reed and later, Brooke Army Medical Center in San Antonio. There were several surgeries, the amputations moving up his ankle and calf until the stump was placed just below the knee, and healed sufficiently to support a functional prosthesis with a minimum of pain. He and Laticia got married and lived in outpatient quarters at the hospital for a while,

until he was given a Medical Board review and discharged from the Army. Now she works full time at a local bank and he goes to school full time. He moves so easily on his two legs – flesh and titanium – that it is hard to look at him and think he is in any way handicapped, although there have been, and continue to be, struggles along the way.

Still, watching the two of them together, it was impossible to ignore that they have achieved something difficult: they have created a shared version of their own war story. They have taken the story of his deployment – recognizing all the events of the eight months he was in Iraq without her, the way he tried to keep her out of his mind when on patrol, and all the dangers and losses she did not then know about – and found a way to emphasize the bonds that connected them during that time. I do not know if they had formalized this war story before, or whether they created it together there that afternoon, but there was a grace and a beauty in their words that I found deeply moving. As they walked out of my office, Laticia turned to me and said, 'I think we just fell in love all over again.'

Story-Telling

In laying out this array of stories – traumatic and not traumatic, alarming and heart-breaking and funny – my aim is to hint at the wide range of what these war stories can look like, of what a service member's time at war can look like. It is not possible in the short space of one dissertation to reveal all the ways that veterans describe their time in Iraq or Afghanistan, and so I have chosen to focus on this group of veterans because their experiences at war and at home are so distinct from one another. Collected together, reflecting on one another, these men begin to illustrate the individuality of what constitutes a war story, a trauma, or even, as I will endeavor to show later on, PTSD itself.

Although each account is unique, as a group they reveal a number of insights into more than just the variety of experiences lived by veterans who have served in Iraq or Afghanistan. To begin with, not all war stories are stories of combat. Brian says that his time in Afghanistan was the best job he ever had. Tony has an expert's pride in all that his unit accomplished in Fallujah. Derek can laugh about trying to hold up his long legs while riding on a donkey. Much of what goes on in a war zone is affected only peripherally by war.

Going further, even among the tales of combat warfare, stories in which there was danger or horror, there is wide variation in what the veterans themselves find to be haunting or "traumatic." The issue is made more confusing by the fact that "trauma" is a word that has drifted into common usage in the U.S., describing any number of distressing events that occur in the course of everyday life, even those that are unlikely to be remembered beyond the next few months or years. One VA psychologist I know responds to this slippage of meaning by regularly opening presentations on PTSD with a list of what trauma is *not* (at least in clinical terms): it is not breaking up with a partner, failing an exam, or losing a job.

Even a war story, no matter how severe, cannot become a trauma until someone begins to think of it as one (although it may have been the cause of traumatic distress long before that). This transformation from war story to trauma usually happens about the time a veteran is diagnosed with PTSD, a process I will discuss in more detail down the line. Most war stories, however, never grow into traumas, either because they were never traumatic to begin with or because there is some quality of the veteran or the story or the way the story is told that allows it to lose its power, to loose the vigilance of its grip on memory and the senses and to remain just a story.

So it was that the events described in the stories above, although some are deeply troubling, were rarely considered to be traumatic by the veterans themselves. There were exceptions. Brian expressed his feelings of horror and helplessness after the mass casualty in Iraq; Jesse talked about the fear he felt under mortar attack, and the powerlessness of hearing a wounded soldier dying on the other end of a radio broadcast. However, I found that – when prompted gently with open-ended questions about 'day to day life in Iraq,' or by a question following up on a loose phrase that hinted at some unsettling truth beneath[2] – few veterans spontaneously raised descriptions of the more horrific events. There are many possible reasons for this, including the always uncertain etiquette of introducing disturbing images or emotions into a conversation. How does someone bring up, for example, that he has picked up the pieces of his best friend's body? Or that he has witnessed the dismemberment of a child?

On the other hand, this desire to avoid talking about truly traumatic events is also considered to be emblematic of PTSD; the effort at what mental health professionals call "avoidance" is one of the criteria for diagnosing the disorder. Most of the veterans I spoke with had been through at least some therapy with mental health professionals, and were – when we sat together in a small hospital room –predisposed to speak to me in a comparably intimate way, no matter how frequently I clarified that I am an anthropologist, not a clinician. Many came prepared to share difficult details about their lives, including dozens of war stories associated with a degree of fear or shame, and yet relatively few offered up descriptions like

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[2] Although there is a written record of traumas reported by veterans who completed the PDS study survey, I did not pry into painful memories in our conversations. If a memory began and was left half-told and then abandoned, I let it rest. Alternatively, I never asked about the good stories, about the best memories a veteran might have of the military. What I did was ask things like, 'What was it like growing up where you did?' 'What was your day to day life like in the military?' 'In Iraq?' Prompted by such general questions, these were some of the stories that emerged.

Brian's or Jesse's. It was more common to hear something like Tony's description of Fallujah, with its emphasis on the detailed work of mounting an offensive suddenly disintegrating into fragments that reference rather than revealing the trauma of the battle. References were frequent; details were not.

This seemed to be because some stories stick in ways that protest retelling – either because they are too hard to tell, or because there is no one to whom to tell them. They can be, as Brian said, too overwhelming to remember. There may also be no one to listen, no one who cares to hear. There are certain stories one does not want to inflict on the listener, on certain listeners, perhaps particularly on those loved best. Brian was perfectly happy to tell me about responding to a mass casualty after a suicide bomb attack, when so many died so quickly that the sky rained blood and gore, but this was not something he wanted to tell his wife. There can be a certain sort of protective wistfulness in not sharing such stories, as though the not-teller is putting forth a silent wish, even as that wish may remain a barrier between the not-teller and the not-told.

May your sky never be one from which blood may fall.

(As mine is; we live, now, beneath separate skies.)

Trauma and Meaning

It was, however, in considering the issue of *which* memories veterans found so horrifying, so disturbing, and so unmanageable that they register as traumatic, that I first began to appreciate the place of culture and meaning in the acquisition of PTSD. For when veterans describe their traumas, they typically describe them in the context of other memories which – albeit awful – they did not find to be traumatic. Brian described seeing dead Iraqis during the

first Gulf War and being saddened but not overwhelmed by it, before describing what was to him far more upsetting: the inability to save Iraqis placed in his care after a suicide bombing. As a medic, it was the deaths of those he had tried to save that was traumatic, not just the fact of people dying. That said, certain traumas do seem to run along common lines: many veterans narrate experiences like Jesse's in which children were hurt or killed in the course of combat action. Frequently these individuals also describe how these children reminded them of a son or daughter, niece or nephew.

Looking at these veterans' trauma stories as a collective, then, reveals two things. First of all, an event that is pathologically traumatic for one individual may not be so for the next, and as a result, we can conclude that there is a great deal of individual variation in the experience of trauma. This variation is likely driven by both life history and physiological factors; for example, for the veterans traumatized by seeing injury to children, their horror may be exacerbated both by having a beloved child in their own lives and/or by having a genetic vulnerability to experiencing events as traumatic. Second, and with the potential to affect both individual and group variation in responses to trauma, there may be a role for meaning, inevitably embedded in cultural signs, systems, and beliefs, in determining *what events are experienced as traumatic*. Culture, with its capacity for shaping the emotional resonance of events throughout the life course, would seem to play a central role in making this determination.

A certain sub-group of these veterans' trauma narratives illustrates the place for culture – and in particular, meaning - in turning up (or down) the perceived trauma of an event. Many of the veterans in this sample were non-commissioned officers (NCOs) during their time in the military. The position of NCOs within the social and power structures of the military is marked by a responsibility to preserve the well-being of soldiers under their command. The importance

of this responsibility is matched only by NCOs' duty to complete their mission and to obey their commanders, following the orders that come down the command chain. When these obligations come into conflict, the results can be devastating. The classic example of this, and a running theme in NCOs' trauma stories, occurs when another service member, particularly a lower-ranking one, is hurt while following orders to which the NCO personally objects. This was the case in Derek's experience of losing his best friend to the orders of his superior officer, orders that Derek protested at the time but had also, along with his friend, felt compelled to obey. His story, and others like it, reveal that the trauma of these events lies not only in the wounding of a fellow soldier, but in the inability to protect a subordinate for whom one feels deeply responsible, and the sense that the damage might have been prevented. Thus the meaning of events creates much of their resonance, and their cultural embeddedness – in this case, in the communal socialization and strict power structures of the military – is partially responsible for the emotional overload that defines trauma.

However, even acknowledging what culturally embedded meanings can contribute to the traumatic resonance of certain events, research has shown that trauma is rarely enough to result in PTSD. As I will discuss in the next chapter, epidemiologists have demonstrated time and time again that trauma exposure is a necessary but insufficient cause for PTSD. In order to more fully understand what puts veterans at risk, we must continue to follow their trajectory beyond combat to the end of deployment, and to those moments when they discovered that leaving war would not mean finding peace. In the next chapter, I begin to explore why so many veterans say that their time in Iraq or Afghanistan was the easy part, and why what turned out to be more frightening was the last thing they expected - coming home.

Home Again

Early Experiences of Post-Deployment Stress

Chapter Three

When Brian's 10 months in Afghanistan were up, his Army Reserve unit climbed into their vehicles and drove five hours from their fire base to Bagram Air Field. Three of those hours involved passing, weapons at the ready, through hostile territory. With his usual brio, Brian describes the tenseness of the drive, then shrugs and says, "When you're there, you're *always* switched on. You can get up and get dressed without ever having a cognitive thought or doing anything. You're up, your boots are on, your body armor's on and you're walking out the door and you say, 'Well, I'm awake *now*.' But you did it all automatically." Upon reaching Bagram, they waited 15 hours for their C-5 plane to arrive, then climbed aboard for the ten hour flight to Germany. Brian remembers that the flight was brutally cold. The men laid down to sleep, huddling up together on the aluminum floor in an effort to stay warm.

They were in Germany just long enough "to drink beer and get into trouble," before they were told they were about to miss their flight home and hopped a bus back to the airfield. There was another ten hour flight from there to Atlanta, and then a bus to Ft. Benning, where they spent three days doing what the Army calls "out-processing" – filling out paperwork ,

attending briefings, and returning the gear they'd been issued – before the last flight brought him home to San Antonio.

"So in 7 days," Brian concludes, "I went from getting shot at to sitting in my recliner. And…pardon my language, but that's called the Afghanistan mind-fuck. Because you come from, 'I'm here,' to 'What the hell do I do now?' And I'm literally sitting in my recliner and I have a thought, 'How the hell did I get here?' because it was so fast." I ask him how long it took him to get over that feeling, and he says it took a year, at least, "to get back to some sense of normalcy." He tries to explain, and can only do so in comparative terms. "Being deployed is easy. You just have to stay alive."

I heard some version of this statement at least a dozen times, from veterans and soldiers and support personnel alike. I spent an afternoon in Killeen, Texas, in a workshop of psychologists and social workers from Ft. Hood, many of whom had deployed overseas or whose spouses had, and listened as they talked about how much easier many soldiers find life in Iraq. 'You don't have to go buy milk in the middle of the night,' one of them said off-handedly, and the others laughed harder than seemed reasonable, the way people laugh when a simple statement sums up something far more significant, something both ludicrous and true. I was expecting Brian, with his usual humor, to say something similar, but he took it in a different direction.

"Have you ever seen 'Band of Brothers?"

"No, I haven't."

"There's a line in there where one of the lieutenants is standing there fighting, and he is talking to this guy who's hiding down in his foxhole. And he says, 'You know, Clyde, the thing you have to realize is that you're already dead. Once you realize that, then you can function as a

soldier.' And it's very true. Once you grasp the fact that you're already dead, you might as well just do your job and drive on. It makes the job easier over there. It makes it a real bitch coming home. Because you're used to being dead and now you got to be alive again."

Transformation

For Brian, as for so many others, the problem wasn't what happened in Afghanistan or Iraq so much as what happened when they came back to the States. Their experiences at war followed them home, partly in their memories and partly in a profoundly altered set of physical and emotional responses to the world around them. Over time, many of these men would learn to refer to many of these responses as symptoms of PTSD. There were exceptions. Some of these responses would be called by other names, like "readjustment," or "depression," or "violence". But in the end, all of these labels would be sought or rejected or applied for complex reasons, reasons that have much to do with the cultural and historical moment in which these veterans live. We will explore this labeling, and the cultural and historical legacies at work in it, in later chapters. But in order to understand the responses and experiences that come to be called PTSD, it is necessary to begin with the phenomena themselves. This chapter, therefore, explores a deceptively simple question: what happened to these veterans when they came back home?

Adam is a long tall 30 year old with short grey-blond hair. He stands out among the study's veterans in that he grew up on the wealthier side of Houston. He joined the Marine Reserves, not because it was the best among a slim selection of opportunities, but because his grandfather was a Marine in WWII and he wanted to follow in his footsteps. When his unit returned home from seven months in Iraq, his plane was met by fire-trucks shooting plumes of

water in a triumphant arc over the runway. His unit was given a police escort from the airport to company headquarters, where they received a hero's welcome from families standing on tarmac lined with TV news cameras. His unit was based in a small town, so in contrast to one of the larger bases – where men and women come and go from overseas almost constantly - their return was something out of the ordinary and the town wanted to celebrate. He found his parents and his wife among the crowd and everybody cried and there were hugs and kisses and photos and speeches and then everybody went home.

Adam had married his new wife a few weeks before his deployment, so in eight months of marriage they had yet to spend more than a few nights in the same place. While he was in Iraq, she had gotten them an apartment and furnished it. He went home to the new apartment with its unfamiliar layout and new furniture and closed the door behind him and didn't leave for five or six days. That first week, there was a steady stream of friends and relatives coming by, but after that things began to settle down.

I asked him, "What was it like? What were you expecting when you got home?"

He laughs, a little disbelievingly. "I don't know. I was more afraid of coming home, honestly, than I was of going to Iraq. I don't know if you've heard that before, but you just, you lose a sense of what normalcy is like. Does that make sense? You forget what it's like to watch TV and sit on the couch and you just…you lose all that. You lose the sensation of walking in grass, walking on carpet, you don't know what it's like anymore…"

Adam trailed off and then spoke again, sounding for a moment very much like Brian. "You're scared when you go to Iraq, I think, your first time. You're nervous, whether you admit it or not. But you get there and you start doing your job and you stay scared, and that's how you stay alive, is you stay scared. You're alert. And you get so used to it, that's just life. That's

just the way it is. And so you almost fear coming home, because it's another huge change for you. You're excited, because you haven't seen your wife or you haven't seen your kids, or your parents if you're single, or your girlfriend if you have one. But you're scared. You're scared of how much you've changed, of what they're going to think of you, of how they're going to react. I don't know if that makes any sense but…yeah, I was very nervous coming home."

One of the first things that many veterans noticed about their post-deployment selves was an internal shift in their perceptions of the world around them. Adam talks about the intensity of those first weeks home, his attention caught by small things, like a new version of Sprite that had come out while he was away, and the color of grass, and the fact that the air in Texas didn't smell like sewage, as it had in Iraq. His perception of sights and sounds and smells had been transformed during his time overseas, and it was a while before he again became re-accustomed to the sensory inputs he had taken for granted before deployment.

Some of these changes in perception, however, were more significant than others. Cars backfiring now sounded too much like gunfire. Trash on the side of the road looked an awful lot like the debris that is used to camouflage Improvised Explosive Devices (IEDs) in Iraq. Driving itself became a challenge, with other drivers on the highway coming up suddenly on one or another side of Adam's car (now no longer a military truck or Humvee), as if in an ambush.[1] After a year of running convoys or going out on patrol in Iraq or Afghanistan, operating under rules of military engagement, even the rules of the road back at home took some getting used

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[1] It is difficult to overstate the importance of driving as a source of frustration and distress for many OEF/OIF veterans. For example, three veterans who had undergone PTSD treatment were interviewed on video in a recent effort by the VA's Trauma Clinic to use veterans' own success stories and testimonials to improve retention rates in their therapy and psychoeducation groups. All three, unprompted, mentioned how difficult they had found driving prior to their treatment.

to. There were other changes as well. Walmart and its long lines of people, once just the bane of a shopper in a hurry, now seemed like a place of too many people, with too many corners for unseen assailants to hide behind. Adam was taught in Iraq that crowded areas – markets, busy streets – were dangerous. When he returned home, he found that Walmart too now seemed dangerous. Its crowds made him feel "antsy, insecure, unsafe." Adam's awareness of the world around him had changed so dramatically that he could no longer return to his old way of distinguishing between threat and safety in the environment around him.

This was partly a result of his military training and the skills he had been taught for moving safely through perilous or unfamiliar spaces. Lessons like keeping his head on a swivel, keeping his eyes scanning the surroundings for a possible threat. Keeping his body poised for a quick reaction, if necessary. Being alert at all times. Never letting his guard down. Never sitting with his back to a door. After seven months in a combat zone, these lessons were so deeply ingrained that they had become automatic, patterns imbedded in his muscles and nerves. Two years after leaving the military and returning home, Adam said that he still finds himself reaching for the pistol he no longer carries.

He is not alone in this. Three years after getting back from Afghanistan, Airman Chris Monroe can still be caught off guard by colored tiles installed in the hallway of the company where he works. Walking along a white hallway, lost in thought, he will catch a glimpse of a staggered yellow or red blotch on the wall and find himself checking his peripheral vision, his sense of danger switched on by the startle of a visual out of place. There is a two-story atrium in his workplace that, for months, he found it impossible to walk through. He imagined snipers hiding behind columns on the upper level, targeting him as he walked beneath. Even worse are the echo of other sights that still linger behind his eyes. He remembers too many dead bodies,

of friends and strangers, and finds these images superimposing themselves on the living faces around him. "Whenever I look at people, I know what they're going to look like dead. I know what they look like with their brains blown out or jaws blown off or eyes pulled out. When I look at somebody I see that, to this day."

This transformation of sensory perception helps to explain what those familiar with PTSD call "triggers." A trigger is some sight or smell or event that prompts a memory, a memory that can be, depending on its content, associated with a significant amount of distress.[2] Jesse accidently burned the hair on his hand during a family barbecue and was so assaulted by a remembered smell of burnt hair and flesh that he threw up, there on the grass. Sounds that resemble gunfire, trash by the side of the road, the faces of people who look Middle Eastern – all of these represent triggers commonly reported by veterans who served in Iraq or Afghanistan, just as the smell of rice and the sound of Asian languages were reported as triggers by Vietnam veterans a generation ago. These triggers may be specific, bringing to mind a particular incident, but they may also call up a more generalized feeling of anger, sadness, anxiety, or fear. Derek was driving home from his class at the university one afternoon when he saw the silhouette of a man holding what looked like a gun on the overpass just ahead of his vehicle. Thinking it was a sniper, he swerved his car across three lanes of traffic before he realized it was a policeman using a radar detector to check traffic speed. He was thankful that he hadn't hurt anyone, but embarrassed and humiliated that his reaction had been so severe, so seemingly irrational.

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[2] In theory, triggers might also be associated with positive feelings, although I never heard the word used that way by clinicians. But Derek, for example, came to associate the sound of helicopters with protection while he was in Iraq, and says that if he could just get a recording of Black Hawks to play by his bed at night he would "sleep like a baby."

Most of the veterans I spoke with described first thinking that something about them was different – not necessarily *wrong*, at least at first, but *different* – when they began noticing these changes in their reaction to what was going on around them. Jesse says he was "kinda jumpy," and "always waiting for something to happen." Adam said he was on "sensory overload." Another veteran told me that "you feel unsafe at the same time you know you're safe," and admitted that, while driving, he feels like "somebody's going to jump out of the car and shoot me up." This is one reason many veterans give for drinking too much after they get back. Military personnel are forbidden to drink in both Iraq and Afghanistan, out of respect for local Islamic law, so alcohol has the rediscovered novelty value of having been (at least mostly) unavailable during deployment. More importantly for many of these veterans, alcohol also acts as a mild depressant, helping to numb down the constant vigilance and "take the edge off."

Although this feeling of living in an environment of perpetual threat is problematic enough for the distress it creates, it also gives rise to other problems, not least of which is the gap it opens between those who see the world as dangerous and those who don't. A veteran who has been through combat knows, in an unshakeable way, that life is finite and full of risk. His friends and family, however, especially if they are civilians, may or may not share this way of seeing things. Tony describes going to public events with his friends and making "stupid comments" like, "We need to be more aware of our surroundings and our situations, because if anyone wanted to, they could literally take thousands of people out right now." He mimes his friends rolling their eyes and groaning, "Why do you always have to say stuff like that?" "Because it's true," he answers, before adding, "Well, to me it's true."

Tony's friends, on the other hand, have an idea, shared by many who live in a relatively safe society, that war and violence should be left overseas. A veteran should come home and

put down his gun and go back to normal, where normal means shopping at Walmart and driving on the highway without fearing snipers and explosives. Normal is supposed to mean relaxing the wariness that was a survival skill in Iraq. This is a big part of what Brian and Adam mean when they talk about getting back to normal, this ability to feel safe in their home environments. But for veterans whose senses are on constant alert for potential danger, there is plenty of ongoing nastiness back at home to justify their continued wariness. Tony – who, having grown up with so much violence, already had more than a passing acquaintance with brutality when he left for Iraq – was the victim of an unprovoked attack that took place between deployments. He went out drinking with his fellow Marines one night and left the bar a few minutes before his friends, planning to surprise them in the parking lot. On his way to the car, he was jumped by three men, one of whom was wielding a baseball bat, and beaten so badly that his skull was broken and his cheekbone caved in. In a similar story, an older veteran who nearly lost his arm after being shot in Baghdad was later assaulted on a city bus in New York.

Events like these only reaffirm veterans' awareness that mayhem can appear suddenly out of a clear blue sky, in the most tranquil of places. They may be told by loved ones that, now that they're home, everything is going to be alright. In direct contradiction of such assurances, 8 of the 50 men in the PDS study (16%) had witnessed another person being assaulted or killed since returning from deployment. Another 8 had been robbed or had their home broken into. One man had been subject to sexual assault, and another 6 (12% of the sample) had been physically assaulted themselves.

Hearing all this, one might think that the men in this study walked around in a state of ever-present fear, but this was only very rarely the case. Far more frequently, they described *anger*, anger that came out of nowhere, in response to events that might seem trivial. Anger,

they said, that lasted longer and felt sharper than it should. Jesse gave the example of being cut off by another driver on the highway. "A week from then, I'll still be pissed off, like 'That guy who cut me off!' Somebody will be like, 'I can't believe you're still pissed off about that!'" He says he will get "overly mad." He is not sure how or why this happens. He recounted a recent encounter with a rude salesclerk who so infuriated him that he began screaming at the terrified clerk, who took off running. He says this was when "I really scared the shit out of myself." He says, "I don't know why I get like that. It's just the way I am now. If I'm not sad now, I'm pissed off." Another veteran mentioned accidentally running his car into the side of his parents' garage. His response was to ignite, he said, like "gasoline," jumping out of the car and ripping up a small tree newly planted nearby, then throwing lawn chairs and trying to push over some pillars in the yard. As he was telling me about it, he made a wan joke about how funny his tantrum would have looked if caught on video, but like Jesse, he was baffled and bothered by the extent of his own rage. He coped, in part, by trying to stay within a few miles of home, carving out a bubble in which he felt less likely to be surprised or caught off guard.

There are, of course, consequences to walking around with so much anger. Tony, who got into a series of barroom brawls after he was attacked, says that his anger began to interfere with the way his friends and family saw him. "I think it makes me out to be more aggressive than I really am. Instead of being laid-back and cool like I am in my own backyard. Everyone's like 'You're totally different at home.' In my world, in my comfort zone. When I'm out of it, I'm like a totally different person." After a few nights of going out with friends, only to be thrown out of the bar or restaurant for yelling or fighting, a number of his friends stopped calling.

There were yet more devastating changes that these men saw in themselves after returning home from war, changes that had become a source of private grief. For it wasn't just

that the world had changed in their perception – had become nastier, more dangerous, more frightening and infuriating. The world had turned out to be a disappointment, true, but too often they had found themselves to be a disappointment as well.

The first time Chris' unit was shot at, he didn't shoot back. He didn't identify a target. He didn't do any of the things he had been trained to do. He pissed himself. He froze for a few seconds. And then he began shooting wildly. "I went through magazine after magazine after magazine, emptying my gun. I wasn't aiming at anything – I don't even remember what it was. Just blurs in the distance. Much too far away to hit anything." When the firefight was over, he covered up the stain on his pants by low-crawling through some nearby mud and tried to look past the querying looks of his friends. He was utterly humiliated.

This perceived failure hung with him for a long time, particularly after his best friend was killed in a firefight and the potential stakes of every moment in combat became more real. Chris explained how the guilt and shame of these events hung together in his own experience, ultimately creeping into his dreams. "Kind of the underlying thing to the events that affected me was that I had no control over them. And the times that I did have control I messed up. And being completely out of control, completely vulnerable… You feel responsible for the deaths of people." Listening to him talk, I remembered Jesse's story about the child he ran over in Iraq, the child who reminded him of his niece and nephew, and his description of listening helplessly over the radio as the wounded soldier bled to death without medical attention. There is a litany of such stories, beginning with Derek's tale of his best friend's death at the checkpoint he had warned his command was so dangerous. Or that of Carlos, a 40-ish Air Force security officer who saw an Iraqi girl hit by a mistakenly fired grenade launcher. "They thought she was a terrorist and it was a little girl bouncing a ball in the dark." Although he had nothing to do with

the event, Carlos visited the girl repeatedly in the hospital, hiding behind a curtain so she wouldn't know he was there. After he returned home, he began seeing visions in which she was "injured or dead or staring at me or pointing at me."

This haunting, often inexplicable sense of guilt and regret was a central reason that many veterans gave for wanting to go back to Iraq, even with full knowledge of the dangers involved. They worried about their buddies who were still overseas, often now on their third or fourth tours, men and women they had trained or served beside and felt responsible for. Over the months and years that followed, as the wars continued, those who didn't leave the military remained in danger. Tony was miserable when he left the Reserves, worried that he wouldn't be there to take care of his unit if they ran into trouble. Many veterans had stories of friends who were killed upon returning to Iraq, and found their grief mingling with the guilt of not having been there to save them. One young soldier described how ruminating over the fate of his friends kept him awake at night. "I'd try to sleep and I'd remember times that my buddies got blown up, that I'd lost friends over there, and I'd have trouble sleeping. At night, just depression, thinking about the guys who got blown up. Finding out that guys who are over there now, guys who I'd watched get blown up and survive, had died. I'd end up crying until about six, seven o'clock in the morning. All night. Makes you feel like…maybe I coulda done better."

Guilt was only one reason given for being unable to sleep. Of the 50 male OEF/OIF veterans in the PDS study, only one reported that he had no difficulty sleeping, and nearly half reported having a hard time getting to sleep or staying asleep "extremely often." Some veterans were kept awake thinking of their friends, their regrets, their memories; their minds turned relentlessly over and over the same events, unable to change the outcomes. Others

were unable to sleep for different reasons. They found it impossible to relax the vigilance that drove them through the daylight hours, or were riding an unceasing wave of adrenaline.

The need for adrenaline rush after returning from deployment gets talked about a lot among mental health care providers and other support personnel who work with active duty military and veterans, largely as an explanation for the high-risk behaviors that many service members dive into on the return home: unprotected sex with multiple partners; high-speed motorcycle chases without helmets; drinking and drugging too much. One local counselor attended a week-long training and orientation session with a group of newly returned soldiers. He marveled that, even after a full day of exercise and training, the men preferred riding cables down a mountainside in the dark to going to sleep.

Other veterans spoke of laying down at night and waiting with ambivalence for a few meager hours of sleep, needing the rest and yet dreading the dreams that might accompany it. In the course of my time at the VA, I attended a number of psychoeducation groups aimed at OEF/OIF veterans, and one night the leading psychologist asked the group of 10 or so veterans, "How many of you have nightmares?" Everyone raised their hand. Eighty percent of all OEF/OIF veterans in the study reported having at least occasional nightmares about their military experiences, and more than a third said that they have nightmares moderately or extremely often. Brian told me that he doesn't dream, but said also that he wakes up in the night with his heart racing, his body slick with sweat, sometimes in tears and unable to explain why. Jesse dreams of sleeping in camp in Iraq and waking to find himself covered in snakes and scorpions that crawl over him in the dark. One of the women I interviewed, a career airman who served as a nurse in Afghanistan, described nightmares of Afghani children torn apart by an IED. She wakes to the vacant silence of her empty house and turns on the TV to try and blur the images

lingering in her mind. An Air Force security officer who worked overseeing a prison in Iraq mused, looking back, that "[E]very second of the day was that prison. It didn't matter what I needed to do - as soon as something would happen I'd have to get up and run back to the prison. So I never got very far from that prison, and even now I'm still not very far from it - in my thoughts, in my dreams."

Dislocations

In hearing these stories of how veterans first began to realize that something in them had gone awry, I found it impossible to avoid thinking that many of them spoke as though they had gotten lost somewhere in the space between Iraq or Afghanistan and San Antonio. It was as if, halted prematurely on the journey home, they had landed on some muddled middle-ground of reality and memory from which they embarked on both dreams and waking life. For lack of a better word, I began to think of what they described as a kind of dislocation. The word has a medical meaning, of course, describing the "separation of two bones where they meet at a joint."[3] A dislocation is usually caused by "sudden impact" and though such an injury normally leaves the bones themselves intact, it causes damage to the surrounding ligaments, those cords that tie the bones together. But the word also carries other meanings, being "the act of disrupting an established order so it fails to continue,"[4] and perhaps most aptly, "the state of being displaced."[5] What I heard from veterans was a dislocation of experience, rather than one

[3] (MedlinePlus, 2009)
[4] (Dictionary.com, 2009)
[5](Dictionary.com, 2009)

of the body, but the image seemed to capture something of both the injury and the feeling of being thrown out of one's place in the world, the order of things disrupted.

One of the first occasions on which this dislocation became apparent was in the course of a long conversation with Victor, a Mexican-American man in his late twenties. He seemed subdued and distracted as we talked, sad-eyed. Later on, during a quiet moment when he was filling out the survey, he looked up at me and said, "Let me ask you this. Why is it that I wouldn't mind going back?"

"I don't know," I answered. "But I hear it a lot."

"My brother too," he said. "I asked him, 'Why do we want to go back?' We're all, '*Esta bien*, we wouldn't mind going back.' He's the same way. He doesn't know why he wants to go back – he just knows he misses it."

I started to speak, but he went on. "I know I wanted to go back the first time because of my brother [who had deployed shortly after Victor's first tour], and I knew that I had nowhere else to go, too. I'd go back right now, too, because I don't have anything here. Whenever I've been in Iraq, you have so much time when you're there. You walk the sand and you hear guns going off, and tanks firing. And you hear people in the crowd, the merchants. And you feel like nothing was there, nothing's there still. Your wife wasn't there, to bitch at you. Your kids weren't there, to scream at you. I guess it's the fact that you were alone. I miss that. It felt like I was gone anyway, out there. I don't know."

Initially, I was confused by Victor's image of having wandered alone through Iraq, of missing that solitude and longing for it. His other stories of Iraq all involved people – other soldiers, leadership figures, Iraqis. In none of his war stories did he appear by himself, and yet here, in this memory of Iraq, he expressed nostalgia for the isolation. Upon further reflection,

however, it became clear that this longing was inextricably linked to another internal change that many veterans described, a shift from being someone who enjoyed other people to being someone who just wants to be left alone. Victor says that before he went to Iraq, "I was more outgoing, more social." Now, by contrast, he says he doesn't talk to anyone. "I would rather keep to myself than anything. We used to have family events - get together, having a picnic together and everything. Now we don't even do that. My aunt's birthday is coming up. I don't want to go. I know when I was in Ft. Hood, when I was here before going to Iraq, I was very cheerful. I would want to do things, I would want to go out." Now, by contrast, he says, "I feel like everything I'm in contact with is just irritable." One of the Vietnam veterans I spoke with said that he sometimes wishes he could just wander off into the woods and disappear like that, off by himself in the wilderness. Adam did just that as often as he could, driving down to his deer lease out in the country, alone or with another friend who is also a veteran, "just to be alone, in solitude. Just alone with your thoughts."

This urge to isolate was only the most extreme manifestation of a sense of withdrawing from family and friends, and what seemed to be an involuntary flattening of emotion more generally. Jesse described being unable to feel "any kind of emotional attachment to anybody. I *think* I love my girlfriend, but I can't really feel it. I can't feel anything." He gave another example. "One of my uncles died, and we were close, and I couldn't feel anything. Like, I just didn't feel anything. I was sad, but I really wasn't, and I was like, 'What the hell's wrong with me?'" Over time, he realized that it isn't that he can't feel anything at all. He can feel anger, first of all, as when he screamed at the salesclerk or lost his cool in traffic. His range of emotions wasn't the same as it had been, but neither was it one-dimensional. Sometimes he would cry

for no reason he could understand. He compared himself to a pregnant woman, with hormones going wild. "I'd see a movie and I'd cry. I'd be fine and then I'd be crying."

Victor, speaking haltingly, linked a similar kind of numbness to the loss of his sex drive. "I don't even care for [sex]. That's what's weird. I honestly feel so emotionally detached. If you don't feel emotional attached you don't feel for somebody, you don't desire them. That's becoming a problem with me and…anybody I'm with. It's kinda weird that like, you wanna be loved but then you can't be. And that's hard to feel - you'll never be loved." He looked up towards the closed office door as he said this, perhaps thinking of the girlfriend who sat waiting for him in the lounge beyond.

This second kind of dislocation – the feeling of being cut off from loved ones – reverberated throughout the tale of almost every veteran who described himself as struggling in the aftermath of deployment. In some cases this withdrawal was more acute than others. Victor, for example, had sustained a severe leg injury while working as a mechanic in Iraq, and was facing an upcoming surgery to repair the torn muscle. In the meantime, however, he was keeping away from his three children, who were living then with his ex-wife while he bounced back and forth between his mother's home and his girlfriend's. At the time we spoke, he hadn't seen his children in nearly two months.

"I don't want to see them look at me and see me hurt," he explained, looking around him in clear discomfort as he spoke. "With the surgery coming up, I don't want them to see me in pain. It sounds kind of selfish, I guess. I don't know if I'm doing it for the right reasons."

I asked, "Why don't you want them to see you in pain?"

"I don't know," he answered. "I suffer from insomnia regardless, but with the pain, it's hard to sleep, hard to even think sometimes. Especially at nights, I toss and turn and think

about [my ex-wife] and the kids. I think about the kids - I can't pick them up, I can't hold them. I guess that's why. Protect myself from that predicament. Does that sound right? I don't know. I tell myself that I can't give them something I don't have…they live with her, with their mom. So if I don't see them as much, I won't miss them as much."

Most often, however, the withdrawal from loved ones was less direct. Brian described the change he saw in himself between the time he entered the military and his return from the first Gulf War. "Prior to coming into the Army, I was very …I'm a pretty happy guy, I'm pretty jovial. But I'm only jovial this far with you, because I don't know you, and it would take me months before I would be able to buddy up to you …." He paused, then admitted, "My wife and I will never be as close as we were before I – when we were dating and first married. And it's just because I've constructed enough barriers that if anything happens I'm not going to get hurt by it. If she dies I'll be sad, but I'm going to go on. If my mom dies…my sister-in-law, my nieces, I'll be sad, but it's not going to stop my life, whereas beforehand it probably would have stopped me. I would have been so emotionally attached that it probably would have been too painful to comprehend. And part of that, I think, is just a little bit of a disconnect and not being able to have that tight attachment or tight emotional connection."

The double impact of these withdrawals is that they affect Victor's children and Brian's wife as much as they do Victor or Brian. This is – inescapably – the case with all of these post-deployment challenges. A veteran who is avoiding crowded places is likely to have a wife who feels deprived of help with the grocery shopping, and kids whose father doesn't take them to football games anymore, for reasons they may not understand. If a veteran's sleep is disrupted too much or too often, he may be short-tempered and impatient. If he has a history of becoming violent while dreaming or on sudden waking, he may be afraid to share a bed with his

wife or children. The changed experiences of self and world that are so much of the internal landscape of these veterans' lives have an unavoidable impact on the external world they share with their wives, girlfriends, children, parents, friends and family. They are dislocations from what was normal before the war, but also from the very people who mark the difference between 'returning' and 'coming home.'

Deployment and Families

Veterans' internal transformations put additional strain on families already tested by the long separations of extended deployments. By 2007, when I began this study, such separations had become par for the course for much of the American military, although the length of deployments differed by specialization and branch of service. Marines were typically deployed for 6-7 months. Soldiers were deployable for as long as 15 months, up from a year at the time of the Iraq invasion. Air Force personnel were generally looking at 6-7 months per tour, although there was some variability in all the branches. Combat surgeons, for example, deployed for only 3 months at a time, since their work was considered to be so high-stress that they risked burn-out with longer periods. By the beginning of 2007, one third of American troops had served at least 2 tours in a combat zone, and 70,000 individuals had deployed at least 3 times.[6]

This far into the conflicts, the military was recognizing the debilitating affect of such extensive deployments on service members' families, with research documenting increases in

[6] (S. J. Johnson, et al., 2007)

divorce rates among enlisted personnel,[7] and an increase in child abuse and neglect among the children of those deployed.[8] These issues were a common topic of conversation in military and community settings. On several occasions, when attending military- and veteran-oriented events in San Antonio, I heard it said that '95% of marriages are failing!' I found no reports or statistics to support this claim, nor do I know whose marriages were thought to be so profoundly at risk (i.e. military marriages in general, or some more specific group). Regardless, there was an idea floating around that the marriages of military personnel were falling apart, and people were worried.

Twenty four men and women who had lived through the deployment of a spouse, partner, parent or child participated in the PDS study. Although deployment can be incredibly hard on families under even the best of circumstances, these family members described experiences nearly as variable as those of going off to war. Their narratives suggest that certain factors seemed to make deployments more or less difficult to bear. During deployment, the most important determinants seemed to be the number of deployments, the length of the absences,[9] the quantity and quality of communications during deployment, and the state of family relationships prior to the deployment. After deployment, service members often returned home to find that their role in the household had changed during their absence, and found themselves launched into the effort of readapting to their families while their families readapted to them. This process was sometimes made more difficult by concerns about infidelity during the deployment. One Vietnam veteran, when I asked what advice he had for

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[7] (Zoroya, 2008)
[8] (Gibbs, Martine, Kupper, & Johnson, 2007)
[9] Veterans in this study described deployments ranging from 3 to 18 months at a time.

younger veterans, said very seriously, “Don’t ask any questions you’re not fully prepared to hear the answer to.”

Nonetheless, most veterans and family members accepted deployment as a necessary part of military life, and nearly all took steps to manage the challenges it created. Romantic partners, married or not, struggled to maintain a viable relationship across long absences and under the extreme stress of having one partner in a war zone. Those with children found ways to arrange childcare during one parent’s absence, often re-tooling the structure of family roles and responsibilities in the process. The logistical difficulties associated with deployment were daunting; the emotional challenges required creativity and commitment to surmount.

Laticia, Derek’s wife, dealt with the deployment by taking an intimidating courseload so that she could complete her college degree by the time Derek came home. Many of the military wives I spoke with described utilizing similar strategies to “get through” – focusing on work or school or a new job or their children as a way of making the best of the time apart, and of distracting themselves from the constant worry of wondering whether their partner was safe. The amount of communication between family members during deployments varied a great deal. Those deployed early in the conflicts often had to make do with sparse email or telephone contact, since communications infrastructure was slow to develop in post-invasion Iraq and Afghanistan. In contrast, service members deployed later on were sometimes able to manage daily or weekly phone calls, although many found that this accessibility did not lessen the sense of distance. For those, like Jesse, whose loved ones were upset by hearing mortar rounds exploding in the background over the phone line, such contacts could do as much to emphasize the separation as to narrow it. Invariably, no matter how frequent the contact, those deployed and those at home were leading very different lives. While Derek was going out on patrol every

day, Laticia was watching the kids, studying for tests, and - since Derek hadn't been entirely honest with her - imagining her husband safe in a bunker running communications systems. Coming home, then, meant trying to take those different lives and bring them back into alignment.

Josh and Laurie, for example, came into the hospital together to meet with me, although they preferred to be interviewed separately. They made a good-looking pair. He is tall and blond, and she is a cheerful young woman with long hair and green eyes who held their infant son on one shoulder. Josh said of their relationship after he returned home that, "It's hard to live with another person again after a [deployment], because you've had six months of different experiences. So there's a 2 to 3 week adjustment period where you get to know each other again. After being away for so long, each person has their own expectations of what the other is going to be like." Similarly, neither has lived the other's memories. "Like [Laurie] tells me she was up all night watching CNN because she was scared to death, but I wasn't there for it, so it's not real." She can describe what it felt like to worry about him, staring helpless and frightened at the news, just as Josh can tell her what it felt like to work as part of a bomb squad day after day, but these memories are not shared. Josh said it was like "meeting a friend after a year. Familiar but strange."

From his perspective, then, coming home to his wife felt like returning to something recognizable. But for his wife, Laurie, the alterations in him were dramatic enough to reshape their relationship entirely. She mentioned that she had noticed a big change in Josh after his first deployment. I asked, "How so?" and she responded,

"Just different. Different personality. He was such a smart, well, he still is smart. He was so nice. He was the person who'd always calm me down because I was always – 'Ah!

We've got to get this done!' - and he would always calm me down. The perfect balance for me. And then when he got back, he just always wanted to sleep. Didn't want to go out. Wouldn't do anything anymore. And he was getting frustrated himself because he couldn't calm me down anymore. We almost switched roles at that point."

It became much worse after the second deployment, when he was caught in an explosion and sustained a Traumatic Brain Injury (TBI). Josh's injury was closed-wound, meaning that there was no external evidence of any damage to his brain or skull, and the aftereffects were subtle enough that it was several days after he regained consciousness before his unit realized anything was wrong. One of his buddies was the first to pick up on it, noticing that Josh had told the same story three or four times in a row, not seeming to remembering that he had already given them the details. Josh was taken off his normal duties and spent the remaining month of his tour biding his time in the entertainment tent, watching movie after movie and counting the days until he could go home.

Laurie says that this time when Josh returned, all the changes she had noticed before were just "multiplied by a thousand. He'd sleep nonstop, or try to sleep nonstop. He doesn't fall asleep at night really. But once he does fall asleep, he just wants to sleep all the time. He wants to eat all the time, play video games. Very much of a loner. He's always been a bookworm but not really a loner like that." She admitted, "It kinda bugs me. I don't like being a couch potato like that. I like to go out and do things."

I asked her what her reaction was to the changes in him, and she said, "I knew that was part of it. They told us the way the guys were going to be when they got back." Towards the end of his second deployment, Josh's unit had gathered the spouses together and invited a "specialist" in to prep them for their husbands' homecoming. Laurie remembers the specialist

assuring the wives that they shouldn't stress out about cleaning the house because the returning Marines were unlikely to notice or care. Moreover, he said, wives shouldn't expect to understand what their husbands were feeling, because "they do have some issues with what happened out there, and they've seen some awful things." "They told us that they were going to be different," she said, "And they were."

Laurie finds it difficult to know how much of this difference can be accounted for by Josh's injury, or simply by what he has been through. The second time he returned, she says, "He would treat me like one of his Marines. He would just almost boss me around in a way. Even though - it's kinda funny to say, but usually the woman's the boss of the house. I usually boss him around, tell him what to do, especially with his memory issues [related to the TBI]. But he would boss me around. Tell me what to do. He would use a certain tone that did not go well with me. I did not like that. So, a lot of tension with that."

Things were rough for a while, and she threatened to walk out on him more than once. Still, they have worked it out, adjusting their lives to the new baby and to the challenges created by Josh's injury and what would later be diagnosed as his PTSD. I asked Josh, when it was his turn, "How did you get through that?" His answer was succinct: "Talking. Love. Time."

Communication

Talking, and talking about war in particular, is something that veterans like Tony and Jesse can have a hard time with. Even Brian, for whom talking is something of a specialty, admits that he usually sticks to the funny stuff. But the potential fallout of this preference didn't become entirely clear to me until he began talking about one afternoon when he sat looking through his pictures of Afghanistan with his wife, Lisette. He said, "The thing that freaked

[Lisette] out more than anything was when she saw a picture of me with all my stuff on, and I had grenades on my web-belt. She said, 'What are those?' I said, 'Grenades.' She says, 'You're a medic!' I go, 'Yeah.' 'Well, why do you have grenades?' I said, 'Because Mr. Grenade's your friend sometimes.'"

At this point in time, Brian had been on active duty and in the Army reserves for nearly eighteen years, serving in the First Gulf War, in Bosnia, Afghanistan and Iraq. He had been married to his wife for almost all of that time. In all those years, it had never occurred to her that her husband might have a need for grenades. "I guess she had no idea that - she thought I'm a medic, I'm gonna be… Even if I would say, 'Yeah, we went on patrol….' I don't know if she thought I was on a Boy Scouts' mission or what. I guess she thought I was on a hike with weapons." He takes responsibility for her confusion, adding that "I've let her know more in the last two years than I ever let know back to the day we got married about anything in the military." He had been telling me, prior to this, that he and his wife had recently become closer in the wake of a tough period, and I thought he was going to continue along this theme. But his next words brought me up short. "Only because," he admitted, "I don't have anyone else. My brother and my Dad are both dead." Both Brian's father and brother were veterans, and like many veterans, when he talks about war and combat he prefers to do so with others who have lived through similar experiences. Other combat veterans don't need to be reached across a chasm of unshared experience. They've been there. There is no need to explain.

After the deaths of his father and brother, however, Brian began opening the door on his military life to his wife, albeit cautiously. "I would not burden her with knowing…horror," he says, "I wouldn't burden her with the thought of what I'm carrying." He goes on, "because it's hard enough for me. I wouldn't want to have to put it on her to deal with or think about, 'Well,

maybe he's thinking about *this*.' She doesn't need to know." He protects his wife from the burdens he cannot himself set down. There are lines he draws in terms of what he is and is not willing to share. There are things, he thinks, she doesn't need to know. He gave his son a similar response when the boy asked, "Dad, did you ever kill anybody?" Brian turned to him and said, "You don't need to ask that question. It's not something you need to worry about."

Many family members may prefer this way of stepping cautiously over the rough patches of a veteran's war journey. While he was in Iraq, Derek never revealed to Laticia that he was going out on patrol every day. When I asked him why, he said that, knowing how much responsibility she had on her hands while he was gone, "I couldn't feed her worrying about me, because I knew she was going to be worried enough." He says, "Nobody knew. I didn't tell anybody. My mom didn't know. My sister didn't know. Nobody knew that I was going out [on patrol] every day because I didn't want anybody to worry." The truth came out when the three women were gathered by Derek's bedside after his injury. He was on a heavy dose of painkillers and the stories came tumbling out. Laticia says she wasn't angry to learn that he had lied, just relieved to finally understand. Derek thinks his mother, though, was a little freaked out. "She would have been happier if I hadn't told her at all."

There are no easy answers. Both full disclosure and the lack of it have the potential to prove devastating. Victor, whose marriage was on the rocks when he left for Iraq, and whose wife never replied to his letters while he was gone, came home to find that his father had had a severe heart attack and his aunt had died in his absence. Although he and his mother had been in close contact during his deployment, she had neglected to mention either of these events, wanting to keep him from unnecessary worry. He was shocked to hear the truth when he got back home. Meanwhile, his wife was barely speaking to him, furious that he had left her alone

for so long. His children had grown and lived for a full year while he was gone. The home he deployed from had changed radically while he was away. He felt left out of his family's life, and abandoned by his wife, who he believes felt equally abandoned by him. He tried, he says, but they weren't able to close the distance between them. He moved out a few months later.

Separation

After he moved out, Victor felt like he didn't have anywhere to go. He began looking for a reason to stay in the Army, the closest thing he had to a home after his marriage fell apart. His leg injury, however, was severe enough that it led to a medical evaluation and an early retirement from the Army. In the end, he didn't have a choice.

Most of the veterans who participated in the study had separated from the military since their deployments, although a handful were still on active duty or in the National Guard or Reserves. Some, like Victor, faced "early retirement" – meaning they were forced out of the military because they were no longer thought able to perform their duties – as a result of physical or psychological injury or illness. A few were discharged for drug use, inability to meet weight requirements, or as punishment for other offenses. Most, however, made their own choice to leave the military. Some men had completed their service contract (which came in installments of 3 or 4 or 6 years, depending on the branch of service and the length of their career to that point), and found that they had grown tired of military life and frequent deployments. Others stated, like Tony, that they were ready for a "new chapter" in their lives, usually driven by a desire to spend more time with their families, begin a new job, or go back to school. Separating from the military can be as stressful as any major life change – starting a new

job, moving, getting a divorce, etc. – and in fact, can involve taking on several of these transitions at once.

Part of the challenge lies in leaving the military, which has its own way of doing things, its own identity (identit*ies*, really, given the different branches of service and their many internal specializations). The military has its own ranking structures and priorities and expectations. Attending a workshop for civilian health care providers, I heard a psychologist, former Army herself, try to explain that people in the military really "live in a second culture." She pointed out that military training is intended to rebuild individuals into a "group-based culture." Service members don't think about themselves first, she explained. They have to be willing to put their lives on the line to serve a military objective, or to save the lives of their buddies. She read off a list of the Army's 7 "Core Values": Loyalty. Duty. Respect. Selfless Service. Honesty. Integrity. Personal Courage.[10] She insisted that it is essential to respect those values when dealing when current or former members of the military; they make up an ethical code, and one that is not taken lightly.[11]

Veterans re-entering the civilian world face the additional challenge of creating a new identity there as a student, employee, or citizen. Some of this difficulty lies in getting used to civilian life again, and getting used to a different civilian attitude and way of approaching daily tasks. Some of the disparities veterans pointed out were small enough. Brian says wryly that,

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[10] The U.S. Air Force Core Values are: Integrity First, Service Before Self, and Excellence in All We Do (http://www.usafa.af.mil/core-value/). The U.S. Navy (including the Marine Corps) Core Values are Honor, Courage, and Commitment (http://www.navy.mil/navydata/cno/DON_Core_Values_Charter.pdf).

[11] One can, of course, debate whether the military constitutes a separate culture (although I find it interesting that I was asked this question by military personnel on more than one occasion), or whether all service members subscribe with equal devotion to Core Values. From my perspective, it is less descriptive to say that the military is a distinct culture than to recognize that it offers a set of very powerful cultural influences.

after a career in the Army, he is on a different schedule than most civilians. "Five minutes [early] is on time. On time is late." Josh irritably described trying to work with civilians on a shared project, griping that, "In the military, if you don't understand, you don't ask questions about it. You just do it. Do it. You've got a problem, go solve it! "

But veterans who have recently served in a war zone may also have a difficult time appreciating how some civilians establish their priorities. Jesse talks about going, in a relatively short period of time, from deployment to a college environment. At the age of 26, he finds himself struggling to relate to the younger students who make up the majority of his classmates. "I go from that to all these little kids who think they have it so fucking hard and…oh my God!" Carlos admits that, "Adapting to the civilian world has been rough, too. Seeing war and children murdered and raped and beat up and mutilated, I don't understand how people who live here…" He cuts off and mimicks a high-pitched voice: "'Oh my daughter's cell phone broke! I have to get my 4-year-old daughter's cell phone fixed!'" He says, "It's just idiotic to me. It just upsets me how people have these priorities that are like this," gesturing a tiny space between two fingers, "And to them it's just huge!"

Many veterans are like Carlos in this. They find it difficult to adjust back to a world where the stakes are rarely life-and-death. Others may find that the skills they took such pride in learning in the military are not valued in the civilian world, making it difficult to find satisfying work. One officer's wife told me that, even with a distinguished Army career in healthcare and management, and with an MBA earned during his time in the service, her husband still found it impossible to get work after his separation. He was not alone. A full half of the veterans in the PDS study reported having been unemployed for at least 3 months since separating from the service.

For those who did find work, many found that the same problems that were causing problems for them at home – irritability and anger, withdrawal and difficulty communicating, the desire to avoid crowds and other perceived dangers, trouble with sleeping – proved equally awkward at work. An astonishing number of veterans, some 74% of the sample, also reported having difficulty concentrating for more than 10 minutes at a time, a problem that made studying for school or completing tasks at work unexpectedly difficult. Facing these combined difficulties, a full third of the sample had lost at least one job since separation.

Even among those who appeared to be outwardly successful at forging a new post-military life, a surprising number found work to be a challenge. Because Brian was a Reservist, he returned home from Iraq and went back to his old job at a contracting service. This didn't spare him a transition, however. "My co-workers – when I got back I think they were all afraid of how to treat me. They're afraid to say the wrong thing or do the wrong thing. But [now] my friends from work – I say 'friends' loosely, people I work with – we're more back the way we were. That makes it easier to go to work too. When you go to work and everybody's looking at you like you're a freak…." No wonder Tony said of the "politics" of work that, "I tell people, I should have just stayed [in Iraq]. Sometimes it's better over there than it is here."

And even Tony - who has a girlfriend, a close relationship with his family, and good-paying job - shrugs and says, "I'm still trying to change. To become a civilian. I mean, I am a civilian, but in my mind, I'm still – once a Marine, always a Marine. I haven't been able to convert into being a normal civilian. To becoming part of society." He still wears his hair in a Marine high-and-tight, and swears he is going to keep it that way.

Like a lot of veterans, he struggles to say why he has found it so hard to reimagine himself as a civilian. He reminisces about practicing close combat skills with his friends in the

service, then adds, “I miss the camaraderie. There’s no camaraderie out here.” He wonders aloud whether he would be happier working in law enforcement, which many veterans go on to do, because it would allow him to draw on the skills he worked so hard to acquire in the Marines. “What I do is just so stagnant. It’s the same thing every day. Man, I’m wasting away. That’s what I feel like. I feel like I’m wasting away.”

Carlos reiterated this feeling. “When I was a soldier, I was at my prime. I was good at what I did – really good at what I did. Even my wife says I was really good at what I did in the service. I felt whole, part of something. I was doing something. I was making a difference. Now that I’m out, I feel like I’m waiting on something, I just don’t what it is.” It isn’t that he is altogether unhappy being out of the service. When I asked him if he wishes he could go back in, he said, “Yeah, I do, but at the same time I don’t. I have a lot of time, you know, that I can spend with my family, my daughter. Stuff I didn’t get to do when I was in the service. Me and my little girl have a real close relationship. A real strong bond. I’m Mr. Mom now.” But as proud as he is of his relationship with his daughter (a gorgeous little girl in perfect pigtails her father braided for her), he struggles with a sense of no longer engaging in work that makes a difference. He no longer feels part of something larger than himself, and he feels that loss.

Stressful Life Events

In focusing so extensively on the aspects of post-war life that these men found difficult, I don’t want to obscure the fact that many service members come home from Iraq and Afghanistan having gained something positive from the experience, and without what they considered to be lingering negative effects. I interviewed one young couple – the husband was an officer out of West Point and the wife had her master’s degree in counseling – and she threw

her hands up in the air when I asked whether he had experienced any post-deployment stress. With her background in mental health, she said she had obsessed over everything he said or did for months after he came home, convinced he must have PTSD. But he's fine, she said, sounding relieved. Moving throughout the community, I regularly encountered veterans and family members who all asserted the same thing. Perhaps the veteran had some hypervigilance when he came home. Maybe it took a little while to get used to going out without a gun and holster. Maybe he even had a little trouble driving. But these feelings were manageable and passed within a short time.

Even among those veterans who went on to develop PTSD, there was generally an acknowledgment that their deployment had left them with new skills and strengths. Many felt more confident, more assertive, and more appreciative. They placed a higher value on their home country, their freedom as citizens, their health and safety, and their families. Nonetheless, the problems they encountered on coming home were also real, and raise the question: what is it that causes some individuals to struggle with PTSD while others do not? How do we understand this variation?

According to the current 4th edition of the DSM, an event can be considered sufficiently stressful to prompt a post-traumatic reaction if the following two criteria are both met:

"(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror."[12]

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[12] (American, 1994)

Trauma, then, at least in its clinical meaning, describes an event that involved a direct threat to self or others, and that provoked a response of profound stress and anxiety.

Nonetheless, most people experience one or more traumas in the course of their lives without ever developing the sort of long-term emotional disruption associated with PTSD. In 1996, a team of researchers conducted a randomized survey of more than 2,000 individuals living in the Detroit area; they found that 89.6% of those surveyed had experienced at least one trauma, with nearly 40% having survived a violent assault of one type or another.[13] What is remarkable, however, is that only about 10% of these individuals went on to develop PTSD later on. The likelihood of developing PTSD was far greater among those who experienced sexual assault or a violent attack; still, even among those who survived these kinds of violence, the probability of later developing PTSD only rose to 20.9% overall. Other studies report widely varying rates of trauma exposure and PTSD in the general population, largely depending on the population investigated and the definitions of trauma or PTSD used in the study. Even so, these studies invariably come to similar conclusions, reporting a wide gap between the number of people exposed to trauma and those who go on to experience PTSD.[14]

This gap holds true for veterans as well. A recent Army study of combat exposure among some 88,000 military personnel returning from Iraq and Afghanistan found that 66% reported firing their weapon, witnessing death or injury, or feeling in danger of being killed. At

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[13] (N. Breslau, et al., 1998)
[14] (Ronald C. Kessler, Sonnege, Bromet, Hughes, & Nelson, 1995; Perkonigg, R.C., Storz, & Wittchen, 2000)

the same time, only 12% of individuals in this same group were found to be showing signs of possible PTSD.[15]

And so, it is necessary to appreciate that while PTSD is an understandable outcome of living through some of the events described above, it is not an inevitable one. One man's horror is another man's difficult-but-not-devastating-just-another-day-in-Iraq. In Chapter Two, Tony admitted that mortar attacks are frightening, but ultimately shrugged them off as part of ordinary life, whereas Jesse was so afraid in "Mortaritaville" that he slept under his Kevlar like a security blanket, knowing full well it was unlikely to save him if he were hit. Mental health clinicians and researchers have spent decades trying to understand why two individuals may live through the same event and have dramatically different reactions, why one soldier may develop PTSD and another may not. One of the key findings of the work in this area has been the recognition that the accumulation of stressful events over the course of a lifetime increases an individual's risk of developing PTSD.[16] For example, Tony was put at greater risk for developing PTSD related to combat because he was exposed to family and street violence as a child. As his story makes very clear, trauma is not only a characteristic of combat zones. It is abundantly available in the abuses, accidents, disasters, rapes, and violences of life at "peace" as well.

In an effort to consider whether any such accumulation of violence had an impact on Iraq and Afghanistan veterans participating in the post-deployment study, I included measures of both pre-deployment stressful events and combat exposure as part of the interview itself.

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[15] (C. S. Milliken, J. L. Auchterlonie, & C. W. Hoge, 2007b). One may find many reasons to dispute these figures – not least because it is a widely accepted fact (particularly among military epidemiologists) that personnel returning from deployment underreport PTSD symptoms on the forms analyzed in this study. However, the essential point is borne out – far more people are exposed to trauma than develop PTSD.

[16] (Fontana & Rosenheck, 1994; Johansen, Wahl, Eilertsen, & Weisaeth, 2007; Ozer, Best, Lipsey, & Weiss, 2003)

Veterans completed a written survey in which they filled out a checklist of stressful life experiences, as well as PTSD and other symptoms, social support, and other life circumstances.[17] What emerges from these data is the crucial recognition that stressful life experiences were part of life for many of the 50 men in this group even prior to deployment to Iraq or Afghanistan. Twenty percent had already engaged in combat or been exposed to a war zone prior to landing on the ground in Baghdad or Kabul. Twenty-two percent witnessed physical violence between their parents or other caregivers. Another 22% grew up with a parent who had a drug or alcohol problem. Some 30% reported being emotional mistreated – being "shamed, embarrassed, ignored, or told I was no good"[18] – while 52% report being physically injured by another person in childhood, and 4% were sexually abused or assaulted as a child. This is not inconsistent with what one might expect from a pre-deployment military population. A study of more than 15,000 active duty military personnel conducted in the late 1990s (i.e. before the beginning of the current wars) found that 65% of military men and women had experienced at least one trauma in their lives.[19]

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[17] After the survey was complete, I always checked to make sure that the questions had not been upsetting, usually saying something like, 'Was that okay?' or 'How do you feel?' The veterans invariably told me that filling out surveys was fine, that checklists didn't bother them. Those who felt like volunteering more information might say that it was talking about the memories that was a problem, not checking off boxes. The only exception to this rule was of a man who called my cell phone after the interview was over, as he was walking out to his car. 'I lied on one of the questions,' he said, 'I don't know why.' On his survey, he reported that he had never witnessed friendly fire – incoming rounds mistakenly fired by another American unit or Allied Forces. He called to tell me that this wasn't the truth. I thanked him, told him I would fix the response he had given written survey, and asked if he wanted to talk about it any further. He said no, and made a polite exit from the call.

[18] This text is taken directly from the Deployment Risk and Resilience Inventory, subscale A, developed by King et al. (2006) and used as a measure of stressful life experiences in this study. (D. W. King, et al., 2003; L. A. King, King, Vogt, Knight, & Samper, 2006)

[19] (Hourani, Yuan, & Bray, 2003)

The San Antonio veterans who participated in this study, however, did report levels of combat experience that were considerably higher than has been documented among a general sample of those serving in Iraq and Afghanistan.[20] This is to be expected, given that 39 of the 50 veterans in the Iraq-Afghanistan group had been diagnosed with PTSD, and thus were likely to have been exposed to higher levels of trauma and violence. Among this group, 84% reported going on combat patrols or other missions, 98% reported being on the receiving end of incoming fire, and 38% were themselves injured in combat.[21] Another 78% reported having witnessed a fellow service member being injured or killed, and almost half, 48%, believed they had killed someone in the line of duty.[22] These statistics tell us something more than simply that the men in this group were deeply involved in the fighting during their deployments; they also tell us something about how much difficulty veterans were likely to run into upon returning home. During the survey, veterans also completed the Post-Traumatic Stress Disorder Checklist, Military Version (PCL-M), which collects information on the severity of PTSD symptoms within the preceding month.[23] When I analyzed veterans' self-reported PTSD symptoms alongside levels of combat exposure, I found that past combat exposure and current PTSD symptoms were significantly correlated. In other words, those veterans who reported witnessing and engaging in more intense combat in Iraq or Afghanistan were also likely to report more severe PTSD symptoms, and vice versa.[24]

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[20] (Milliken, et al., 2007b)
[21] Combat exposure was measured utilizing the Deployment risk and Resilience Inventory (L. A. King, et al., 2006) Combat Exposure subscale.
[22] By comparison, Miliken and his coauthors, in their study of 88,000 soldiers returning home, found that only 54% had witnessed someone being wounded or killed, and only about a quarter of the sample had even fired their weapon.
[23] (Weathers, Litz, Herman, Huska, & Keane, 1993)
[24] With a one-tailed Pearson correlation score of .355, significant at the 0.01 level.

On the other hand, pre-deployment life stressors were not, as it turned out, predictors for current PTSD among the men in the PDS study. There was no significant correlation between exposure to early life stressors and the severity of current PTSD symptoms. This is, I suspect, a function of the relatively small sample size, an impression supported by the findings of two much larger recent studies among American and Israeli veterans, both of which reported that exposure to adverse childhood experiences appeared to be associated with current PTSD status.[25]

Well-being and Social Relations

In addition to PTSD symptoms, there were other challenges these men faced when they returned home. Most went through a separation from the military, although a few stayed on active duty or in the National Guard or Reserves. Those who left the service embarked on the process of creating a post-military life for themselves. More than a third of these veterans (38%) were also injured in combat, with wounds ranging from scrapes and bruises to severe burns and amputations. Those – like Derek – who faced injuries requiring long-term care were forced to put military, school, or career ambitions on hold, at least for a time, while they shifted onto a trajectory of recovery and rehabilitation.

Among all the myriad experiences of home-coming, however, one of the greatest sources of variation was the social world the veteran came home to. Most of the PDS study's veterans returned home to wives or girlfriends, but veterans and support personnel often

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[25] This is, I suspect, a function of the relatively small sample size. Two much larger recent studies among American and Israeli veterans did find that adverse childhood experiences were related to current PTSD status (Cabrera, Hoge, Bliese, Castro, & Messer, 2007; Solomon, 2008).

suggested that single service members may be at particular risk for becoming isolated after deployment. One veteran, whose marriage had fallen apart prior to his tour in Iraq, said that when he returned home, "I didn't want to be home. I wanted to be back over there [in Iraq]. I got nobody back here. I see everybody else has wives, kids, fiancées, girlfriends, and they're all happy, and I'm just getting off the bus, just trying not to cry. There's nothing for me here, why not just stay over there?" He moved into an apartment equipped only with a mattress and a TV, and took refuge in his work and his friends.

Another veteran expressed frustration with the lack of tailored support programs for single soldiers. The very next day, I happened to be interviewing a woman who runs a soldier support program on Ft. Sam Houston, and when I mentioned this complaint to her, she nodded. She began telling me about a soldier – age 30 or so – who had worked with her while he was receiving treatment for burns at BAMC. After a year or so, he took leave and went home to visit his family and friends in Oregon. She found him in tears one night shortly after he got back, and he told her, 'I don't belong there anymore.' After the first two days of visits and parties, his friends had stopped calling; they were all married and had kids of their own now. 'Everybody else has gone on with their lives,' she said. She added with mild sarcasm that she wasn't sure if his friends were even fully aware that there was a war on, before concluding that, 'He just doesn't fit the puzzle anymore.'

Sitting in her office, I was struck by the number of devoted parents who wandered in and out, passing time at the hospital while they waited to visit their wounded sons and daughters. But most Americans past a certain age do not go on living with their parents. Among the single veterans in this group, it seemed to be more common that they would move straight from military barracks to an empty apartment (complete with mattress and TV). Those who had

not yet begun to pair up and create a nuclear family of their own may have begun to feel increasingly left behind.

Even for those service members who return to wives or girlfriends, there is no guarantee that all will be well. Suicide among military personnel has been on the increase in the years since the war started. The most recent annual report, released February 2009, found that 2008 was another record year for Army suicides since record-keeping began in 1980, with 128 completed, confirmed suicides. This puts the Army suicide rate at 20.2 per 100,000, surpassing the 19.5 per 100,000 rate in the nation as a whole, which is remarkable largely for the fact that the military has traditionally had lower suicide rates than the general population.[26] In May of 2007, the press reported that Army officials were, as one article put it, "reluctant to draw a link between combat exposure and suicide" and instead pointed to failed personal relationships stressed by long and repeated deployments.[27] Col. Elspeth Ritchie, chief psychiatrist for the Army, said during a conference call with reporters that "multiple deployments and long deployments put a real strain on relationships…" She also noted that "there's also normal girlfriend-boyfriend breaking up, marital difficulties that arise in both civilians and soldiers."

My initial response to hearing these statements was, I must admit, some frustration at what seemed to be a blatant minimization of the role of combat exposure in soldier suicides. The epidemiological data, however, do bear out the influence of personal relationships on service members' health and well-being, both during and after deployment. Among soldiers who committed suicide in 2007, fifty percent had a "recently failed intimate relationship".[28]

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[26] (Starr, 2009)
[27] (Chedekel & Kauffman, 2008)
[28] (*Army Suicide Event Report Calendar Year 2007*, 2008)

One couple I interviewed told me about a phone call during deployment that was interrupted when the man on the phone next to the husband took out his gun and shot himself; his girlfriend had just broken up with him over the phone.

In addition to shaping suicide risk, relationships also play a role in mental health more generally. Research conducted since the 1980s has consistently shown that social support is an important piece of understanding warriors' vulnerability to PTSD. Higher levels of social support – that nebulous term that roughly describes having people to turn to for practical and emotional help and encouragement – have been found to mediate the effects of combat exposure and to predict lower susceptibility to PTSD and greater resilience to stress.[29] In one 1994 study, Fontana and Rosenheck found that two factors made the greatest contribution to PTSD risk among Vietnam veterans: combat exposure and a lack of perceived support from friends and family at the time of homecoming.[30] A variety of other studies have come to similar findings,[31] which makes sense. Social support is regularly found to help protect against most mental health problems, so why not PTSD?

The challenge with PTSD, however, is that although social support can be protective, there is evidence to suggest that veterans with PTSD symptoms are likely to receive *less* social support over time. PTSD can have a detrimental effect on social relationships, so that those who develop PTSD may find they have fewer social ties to draw on as the years go by. This pattern was first identified in a retrospective study of Vietnam veterans in 1985, and more

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[29] (Ahern, et al., 2004; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Taft, Stern, King, & King, 1999)
[30] (Fontana & Rosenheck, 1994)
[31] (Dirkzwager, Bramsen, & Van der Ploeg, 2003; L. A. King, King, Fairbank, Keane, & Adams, 1998; Solomon, 1987; Stretch, 1985)

recently replicated in a longitudinal study among veterans of the First Gulf War.[32] It points to a vicious cycle in which struggling veterans may find themselves with dwindling access to the social resources necessary for a good life and sense of well-being.[33]

Of course, most of the time when Americans talk about "supporting the troops" – which, during the early years of the wars in Iraq and Afghanistan, happened a lot – they are talking about a different kind of support altogether. "Supporting the troops" has become a catch-phrase for actions taken at the community and national levels: providing funding for active duty military and veterans' services; ensuring the proper equipment is available to protect troops in combat; demonstrating support by greeting service members at the airport; posting signs and banners and bumper stickers that proclaim some version of "Support the Troops!" on businesses and billboards and automobiles; and offering up a sense of gratitude, honor, and respect for military service. On nearly every flight I took out of San Antonio during 2007 and 2008, the captain asked passengers to give a round of applause for the service members on board - because there were always service members on board - to thank them for their service to the nation.

Such gestures were remembered, most often with appreciation, by veterans in the study. In large part, however, the support that veterans talked about needing was the kind that takes place at a much more intimate level – within their marriages and partnerships and within their immediate families. Given the experiences that these veterans have described upon

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[32](Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; D. W. King, Taft, King, Hammond, & Stone, 2006)

[33] And there is increasing emphasis being placed on the importance of social relationships in shaping PTSD risk and reocvery – Charuvastra and Cloitre (2008) recently reviewed the existing evidence on social support and PTSD for the Annual Review of Psychology and advocated developing a "social ecology of PTSD" that appreciates "how both PTSD risk and recovery are highly dependent on social phenomena."

coming home, it already becomes clear that both deployment and PTSD have the potential to wreak havoc on family life. A host of studies emerged in the years after Vietnam that also spoke to how the families of veterans with PTSD were hard-hit by divorce, substance abuse, and family violence.[34] More recently, research among OEF/OIF veterans and spouses has reported that both partners express lower relationship satisfaction if the veteran is experiencing trauma symptoms.[35] Studies have found that spouses of veterans with PTSD have more emotional distress, more somatic and sleeping problems, less social support, and less marital satisfaction than do the partners of veterans without PTSD.[36] Among the mental health clinicians I interviewed, it was a common thing to note that many older veterans with PTSD have gone through three or four marriages over the course of their lives. PTSD is hard on veterans, hard on spouses, and hard on marriages.

These findings are in harmony with the experience of veterans in this study. Of the 50 men in the OEF/OIF group, 19 (38%) reported having been divorced or left by a partner since their return home from deployment.[37] Moreover, there was a significant inverse correlation between current PTSD symptoms and lower reported social support since the return home. In other words, veterans who were receiving less social support were likely to have more severe PTSD, and vice versa.[38] Veterans who had been through a recent divorce or break-up *also*

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[34] (Matsakis, 1988), (Elbogen, Beckham, Butterfield, Swartz, & Swanson, 2008b), (Glenn, Beckham, Feldman, Kirby, & Hertzberg, 2002; A. D. Marshall, Panuzio, & Taft, 2005)

[35] (Goff, Crow, Reisbig, & Hamilton, 2007)

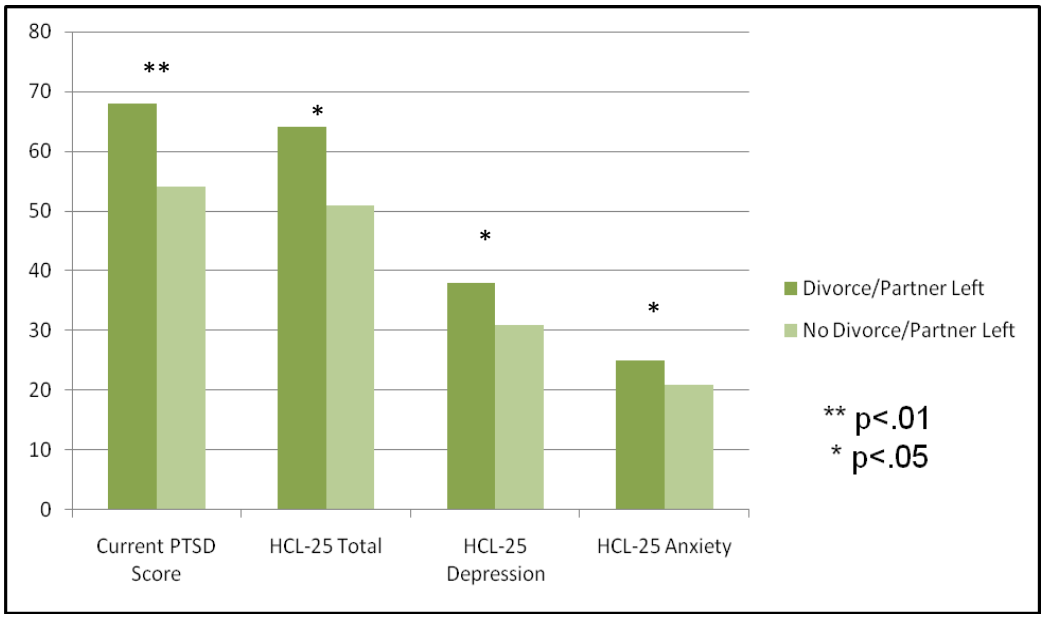
[36](Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005) (Dekel, Solomon, & Bleich, 2005)

[37] The period of time since relationship failure is not standard, and may have occurred anytime since the return from deployment, which ranged from four months to several years.

[38] Looking at this data, there is a significant inverse correlation between current PTSD symptoms and lower reported social support since the return home.

reported significantly lower levels of perceived social support, suggesting that the loss of a romantic partner was a heavy blow to veterans' sense of having adequate social ties. Going further, survey data revealed significantly higher levels of current PTSD symptoms among veterans who had had a relationship break-up since their return home. As a group, these veterans also had more symptoms of depression and anxiety (see Figure 3-1).

Figure 3-1. Failed Relationships and Distress among OEF/OIF Male Veterans (n=50)



PTSD, then, can erode relationships, but divorce and relationship failures may themselves have damaging effects on mental health. Research has found that divorce is often associated with an increase in negative emotions and symptoms of psychological distress.[39] Some psychologists describe break-ups in terms of grief and bereavement, recognizing the aftereffects as a profound reaction to the loss of a loved one.[40] One study found that divorce was associated with increased physical illness and even excess mortality (although there can

[39] (Stack, 1989)
[40] (LaGrand, 1988)

also be psychological benefits from the end of a bad marriage).[41] A recent article even identified symptoms of PTSD among a general sample of U.S. college students who had gone through a break-up.[42]

Among returning veterans, it makes sense that we would see heightened distress related to the failure of relationships after deployment, because these break-ups come as a sort of double whammy during what is already a vulnerable period. The veteran may be losing a key source of social support (the departing loved one) at the very same time he is experiencing an additional stressful event (the break-up itself). Linda King and her colleagues have found that such postwar stressful life events – perhaps no less than the beating Tony suffered in the nightclub parking lot – can influence the severity of a veteran's PTSD symptoms.[43] Certainly, men in the study who had been through a recent divorce or break-up described feeling intense loneliness and isolation, distress at the loss of daily contact with their children, and a sense of failure and betrayal.

What this data suggests is a downward spiral that can begin in the months after homecoming, with a sort of cyclical effect on veterans and their families. Veterans experiencing the problems of early PTSD - anger, withdrawal, disconnection, emotional numbing - are more likely to have trouble holding together their personal relationships. The loss of personal relationships, in turn, increases the likelihood that they will experience more severe distress, more anger, and more disconnection. Tony described how this sort of cycle had played out in his own life, saying that, "A lot of friends don't call anymore, because when I would go out [after

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[41] (Hemstrom, 1996)
[42] (Chung, et al., 2003)
[43] (L. A. King, King, Fairbank, Keane, & Adams, 1998)

returning home], I would be more aggressive. I would be more alert. Picking fights – not picking fights, but always on the defense. Getting in trouble. Getting thrown out of bars." His friends would tell him, "You're making trouble. People don't want to go out with you." After a while, they stopped calling. "Then," he said, "you start getting lonely. Then you start getting depressed." For someone who had always been proud of his close network of friends, the loss was a very real one.

Aside from what it suggests about the process by which veterans may find themselves more and more distant from the social relationships they need, there is something else I find striking about Tony's depiction of these events. In this story, none of Tony's friends said to him (at least as he retells it), "Gee, Tony, you've been off at war, and you seem to be having some trouble calming down now that you're back home." No one said, "Tony, have you been checked out for PTSD?" Instead, his friends said, "You're making trouble. People don't want to go out with you," and stopped calling.

This story illustrates something important about what happened when these veterans came home, which is that the events and experiences described in this chapter mean very little without an understanding of *how they were interpreted* by those involved. In one of anthropology's most classic works, Clifford Geertz described how culturally-specific interpretations can change the meaning of an event.[44] He cited the case of two small boys contracting their right eyelids, one in an involuntary twitch, and the other in a purposeful wink. Although both boys make exactly the same movement, one is experiencing a random muscle spasm while the other is conveying a complex message, a "conspiratorial signal." This, says

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[44] (Geertz, 1973)

Geertz, is the essence of culture, that the second boy could know that there is a public code in which winking conveys a certain message, and could communicate via that code simply by twitching his eye at a friend. As Geertz writes, "That's all there is to it: a speck of behavior, a fleck of culture, and – *voila!* – a gesture."[45]

Something similar occurs when a phenomenon like Tony's quickness to anger is interpreted as an act of aggression, or, alternatively, as a symptom of PTSD. There is an action or event, which – within a particular cultural framework, such as early 21st century American society – is understood to have a cause. That cause is understood to prompt one of a range of culturally appropriate responses. The schoolboy's twitch, understood to be a wink, might merit a wink in return, or a giggle or a prank. Tony's aggression, interpreted as unacceptable behavior, prompted his friends to stop calling.

In the next chapter, then, I examine the ways that veterans and families understood the problems that began to arise in the wake of combat deployment, probing the cultural influences at work and seeing how they play out in the way that families respond to veterans' struggles and veterans make decisions about coping and care-seeking behaviors. The family, of course, is only one cultural environment through which veterans are likely to pass, and the remainder of Part II considers how veterans' post-deployment struggles are viewed from within two others: the U.S. military and the VA mental health care system. Each of these environments proves to have a profound impact on veterans' experiences of PTSD.

Because for Tony, as for so many of these veterans, it was going to get a lot worse before it got better.

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[45] (Geertz, 1973: 6)

Part II. - Crisis and Response

PTSD in Three Cultural Environments

Of Men and Messages

Ethnicity, Life Goals, and Family Support

Chapter Four

'We have the problem, but we also are the problem.' – Army Veteran Brian O'Neil

Sometime in 2002 - after the United States had begun combat operations in Afghanistan but before it had started the war in Iraq - Technical Sergeant Christopher Monroe was sent home from Afghanistan. An Air Force computer specialist attached to an Army Special Forces unit for the technical expertise he could provide, he repeatedly found himself in combat circumstances for which he had little training. One day, while overseeing a routine prisoner transfer, he became enraged at the prisoner and beat the man severely, breaking his arm in the process. Rather than facing punishment for his actions, Chris was simply sent back to the U.S. Nobody said anything about PTSD, although that would be the diagnosis ultimately written on his medical retirement papers. Instead, after a few weeks back at home in the States with his wife and two children, he was shipped off to Korea for a year, once again leaving his family behind. In Korea, he quickly acquired a reputation as the guy who could out-drink and out-party anybody on base. He got plenty of attention – for example, when he climbed a local water tower and got arrested by the Korean police – but nobody at his new post seemed to think anything was out of the ordinary.

An Anglo with dark hair and thoughtful eyes, Chris was brought back together with his Mexican-American wife, Monica, when the family was rejoined after his Korean tour. They were relocated to England, and amidst all the stress of an international move, the reunion did not go well. There is a name for the awkward period after long deployments during which service members re-acclimate to life outside of a combat zone, slowly relaxing the vigilance they have maintained through their months in unsafe territory. The military and the VA call it "readjustment." Chris was not readjusting. Monica crawled over him in bed one night on her way to the bathroom, and, alarmed in waking suddenly, he threw her across the room. She left him and moved back to the U.S., leaving their two children in his care. As his family life fell apart, he began to slip, drinking more and becoming increasingly troubled and suicidal until his odd behavior caught the attention of his wife during a strange phone call, after which she contacted his superior officers. His First Sergeant accompanied him all the way from England to Lackland Air Force Base in San Antonio, Texas, where he was hospitalized and diagnosed with PTSD.

After that, things became better for a while. He took medication that helped with his symptoms and was released from the psychiatric ward. He and the kids settled in San Antonio while the Air Force processed his medical retirement. He stopped drinking. He found a new job. After a year or so, his wife moved back in, although they still had their problems. Within a few months he fell off the wagon and started drinking again. One night he got drunk and – although he blacked out and does not remember - tried to commit suicide. When he came to, he says sheepishly, "I was being wrestled down by half a dozen San Antonio cops. They threw me in the back of the car and took me to the hospital. Fortunately they didn't arrest me. My wife told them I was a veteran, and actually, considering that I hit them and stuff - I physically assaulted

an officer – they did me a good one. They didn't arrest me, they took me to the hospital, and I stayed at [a local substance abuse treatment facility] for a few days."

That was the turning point. He says now, "I just basically knew I had to do something, somehow, somewhere." He went to the local Department of Veterans Affairs (VA) hospital and asked for help.

The Crisis Trajectory

Chris' story sheds light on the sort of problems PTSD can create for those who care for (in the sense both of loving and of providing care for) veterans and active duty military personnel. His experience makes it clear that veteran and family responses to post-deployment difficulties are driven by a variety of factors. Family members may need to respond to a crisis, such as Chris' recurrent suicidality. Veterans may find themselves slipping into a downward spiral, slowly coming to the realization that the current situation is untenable. Regardless of the initial spur to action, it is essential to realize that the steps that veterans and family members take in response to such events are influenced by the cultural frameworks of expectation and understanding within which these post-deployment phenomena are interpreted – in particular, by American ideas around war-related illness and male gender. Chris' story offers an introduction to three questions that will recur throughout the next several chapters. First of all, what is it that prompts people in different settings – in this case, within families – to identify veterans' post-combat experiences and behaviors as a problem requiring a response? Second, what notions about masculinity, illness, and war-related suffering (and later on, what more structural concerns) play a role in shaping these responses? And finally, how do veterans struggling in the post-deployment period navigate amidst at-times contradictory influences in

making sense of their experiences and embarking on a course of care-seeking or other coping strategies?

In Chris' case, the decision to turn to professional care once he returned home was driven by an accumulating series of problems common to veterans with PTSD. His drinking was out of control. He says about his time in Korea, "[T]o be honest, I don't remember much of it. I was there for a whole year, but I was drunk most of the time." He attacked his wife in a moment of awakening from sound sleep, an event he describes in a manner eerily consistent with what I heard from other veterans and other spouses.[46] "One night she got up to go to the bathroom and was crawling back over me to get back in, and I woke up and – she's petite – and I literally just picked her up and threw her across the room. She bounced off the wall. And it didn't stop there. I was still in a panic mode. I didn't hit her, but I was trying to subdue her and take her out, for the 5-10 seconds until I – it probably felt like an hour to her." It was soon after this that she left him.

It was his desire to kill himself, however, that finally brought the situation to a head. He had remained the primary caregiver for his children while going to school and continuing to work full-time on the base in England. He was struggling to stay sober and hold himself together, but he found that it all became too much. He began planning to kill himself. He says, "At the time I'd kind of just given up, and I didn't know how it worked, so I'd planned to make it look like an accident. I was going to jump off a high building there, in [England]. I routinely went up there to fix antennas and stuff, and I was just going to make it look like I fell. At some point I talked to my wife on the phone, and I just apologized to her, 'No, I *really* want to let you

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[46] Interpersonal violence among veterans and their partners is a complex and important topic that is dealt with in greater depth in Chapter Eight.

know that I'm sorry.' She was kinda…looking back on it, maybe I didn't – I did want to kill myself, but maybe I didn't say it verbatim, but she got concerned and called my First Sergeant, who cornered me on it. And I pretty much fell apart. At this time I hadn't even thought about PTSD. I just kinda thought I was messed up and severely severely depressed."

He was held on the inpatient unit for nearly a month and a half, getting stabilized on anti-depressives while the Air Force processed his medical retirement. When he was released from the military, he went out and found a job and continued his efforts to stay sober. Although he was working 60 hours a week, he found himself drowning in debt and unable to pay his bills. He stopped taking his medications, and after his wife moved back in, he began drinking again. That was about the time when he had the second suicide attempt, and he says that that's when he realized – "at the bottom of a six-policeman dogpile" – that something wasn't right. "I had to do something or I was going to eventually kill myself – I knew that."

One of four crises — persistent thoughts of suicide, domestic violence, alcohol or drug use, and panic attacks — drive many veterans into seeking help, whether while still in the military or afterwards. Of these, the desire to commit suicide is perhaps the most frightening. Of the 50 OEF/OIF veterans in the study (including those with and without a diagnosis of PTSD), 14 (29%)[47] reported having had thoughts of ending their lives during the week before our interview. But violence directed against the self was not the only problem. An episode of violence against a family member, or a rising rage that seems to predict the risk of violence, was another crisis that could prompt an immediate response. Carlos remembers that, "I started having nightmares. I'd been having them before that, but I figured it was just the environment.

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[47] 14 positive responses out of 48 total responses for this item. Two individuals did not complete this item.

Waking up, screaming, kicking…I .didn't think much of it. It wasn't until I woke up one day choking my wife that I realized I had a serious problem, and I went to see the mental health people that day." Heavy use of alcohol or drugs, growing worse over time, was another catalyst, particularly when family members became involved and urged the veteran to get help before the problem escalated. Chris had all of the above.

The only crisis Chris didn't run into – of the four types described by PDS study veterans as the last straw in forcing them to seek care – was a panic attack. Jesse, however, did. He talks about coming to the breaking point. "For four days I had to really concentrate on breathing. That was what really got me to go [to the military hospital]. It was like if I stopped concentrating on my breath I would stop breathing. I thought I was having a heart attack. I thought I was dying. I was really scared." He went into the emergency service, and "They said nothing's wrong, it's all in my head and they want to give me Xanax [an anti-anxiety medication], and I said, 'That stuff fucks with your head.'" He left the hospital without his prescription. "Then it happened a month later, and I passed out there in the hospital in front of my supervisor and two of my friends. And it was like, 'I came back for *this*?'" One of the friends who had witnessed his attack, and who had served with him on convoys in Iraq, told him that he should go over to the mental health service. Jesse was concerned about losing his security clearance if he sought psychiatric care, but his friend, who also had a security clearance and who had also sought help for PTSD-related problems after he got back, reassured him. Jesse went to the clinic and got help.

Like Chris and Jesse and Carlos, many veterans found themselves beginning to accept the idea of having a problem beyond their own control – whether or not they considered PTSD

to be the source of that problem – when events reached a crisis stage. Others came to a point of seeking external help in a more gradual way.

The Slow Decline

Derek and Laticia, for example, first started to think that Derek might have a problem after he was released from the hospital with his new prosthesis. Memory of the IED that had taken his leg remained fresh in his mind. He says, "[I]t took me a while to get down from that. Especially driving on the road, anything that looked like trash or debris on the side... I had nightmares."

Laticia chimes in, "For the record, we were watching TV with my cousin and they flipped it on a channel and there was two guys joking and laughing in the desert, riding in a Humvee…"

Derek nods, remembering the incident. "Mmm-hmm…"

She continues. "And the next second it blew up. And I turned and looked at my cousin and she turned [the TV] off and I turn and look at Derek. 'You ok?' He says, 'I'm ok.'" Later that night they were driving home, Derek behind the wheel, and, Laticia says, "he's driving like a maniac down the highway." She stopped him: "'You're going to kill us – pull over.' And he was shaking, clearly disturbed.'" She drove the rest of the way home.

There were other signs. His fear of crowds was so bad that he couldn't go to the grocery store, to the mall, to Six Flags with their kids. I ask how they dealt with that and Derek answers, shrugging towards Laticia, "She busted me a lot [gave me a hard time about things]."

"Did I?" Laticia asks.

"You busted me a lot."

She nods, accepting this, then adds, “I think I would cry a lot. It was a mix of things – frustration, you don’t understand. You don’t really understand.” Back then, she says, she tried to hear him out, but found it difficult to be patient when she couldn’t make sense of his problems. They fought on New Year’s Eve, when she wanted to go spend the holiday with her family and he wanted to stay home, dreading the party crush. Derek remembers that he was still angry when she came home. She defends herself, “You know – it was going from one lifestyle to another, and then dealing with something I couldn’t even comprehend. To me it was like, ‘my family’s calling, we gotta go to my family.’ It’s my family!”

By spring, however, they had fallen into a pattern and things seemed better. That summer, they took the girls to Six Flags, and Derek was able to stay for several hours before he began shaking, unnerved by all the people. Another night that summer, they tried going out to a club with some friends. Derek says, “I was not having that. Too loud. Too many people. Cannot see everything at once. There was smoke everywhere. And I felt really bad, because we don’t get to go out much, with two kids. She was having a really good time, joking, we saw a show and had dinner. She wants to dance and I’m trying to look everywhere at once. I had the racing heartbeat and I couldn’t breathe, and we had to leave.”

When fall came, he started college. He purposely chose one of the smaller schools in the area, thinking it would be less crowded and less likely to unnerve him. But over time, he found that he increasingly needed to get to campus about a half hour early. “I would walk the perimeter of the buildings and I would walk around inside the building, just looking at everybody and making sure everybody fit and there wasn’t a problem before I went to class. And that started becoming a problem, because – if I was out of one class a little late and I couldn’t make it to one class without walking around? – I had a really difficult time focusing in class.” One day

he saw a man standing on the roof and nearly dove to the ground, thinking he was a sniper. "I knew it was crazy. I was thinking, he's either a sniper or he's going to radio ahead. And then I thought, this is San Antonio. There's not snipers on the roof, nobody's going to blow me up here. But I still had to walk around so I wouldn't be nervous in class."

Wives and family members play a key role in helping to shape veterans' experiences of illness, both through offering their own opinions about what the source of the problem may be and in suggesting an appropriate care response. Wives, in particular, are often the prime movers in getting veterans into treatment, and Laticia was doing her best. She had been telling Derek for months that he needed to go get some help. But the final straw came one day in a class on international terrorism. The professor finished the lecture early and put on a video for the class to watch. Derek says, "And it starts with the Islamic call to prayer, there's one of the jihadist group's flags with the AK-47s, and then this mosque just blew up. And I had to leave class." He was so upset by the unexpected explosion and the triggers of Iraqi sound and symbol that he fled. And that was it. As he saw it, his problems were now interfering with his ability to pursue a college degree and move ahead with his career plans, and that was unacceptable. He spoke with his vocational rehabilitation counselor about getting some help, and within a few days he had an appointment at the VA for a PTSD evaluation.

Derek's story illustrates the second sort of trajectory that many of these veterans followed on their way into professional care. There was no crisis, no single event that forced him into treatment, no immediate danger to himself or his family. Instead, there was a long slow series of events that made it clear to both him and Laticia that he had a problem, one that was not going away, and one that could get in the way of fulfilling both his plans for himself and his obligations to his family. This necessitated action.

A Range of Responses

Both Derek and Chris' stories have the same sort of narrative structure. A veteran comes home, faces a series of escalating problems, and ultimately seeks professional help for a possible mental health problem. He may be urged along the way to get help, whether by friends or family members or his military command. This is an easy story to get one's head around because it fits an understood trajectory for what happens in a time of illness. Something goes wrong, we consider the possibility of illness and seek out help of one form or another.

In the United States, this help is most likely to take the form of seeking out professionalized physical or mental health care, largely because biomedicine is the system of health and illness accorded greatest acceptance and prestige in Western culture.[48] This is not to say that there are not other avenues for help-seeking, for there is a great variety of alternative options available to those seeking support or healing. These may include a church or other religious community, or one of a dizzying array of ethnomedical systems available in the U.S. (of which biomedicine is one), which with all its diversity is home to healing systems transplanted here from all over the world.

This wide array of cultural systems for defining illness has been suggested as one explanation for studies showing ethnic differences in the likelihood of developing combat PTSD. The National Vietnam Veterans Readjustment study found that, while only 13.7% of White Vietnam theater veterans met criteria for current PTSD, rates among Hispanic veterans climbed to 27.9%.[49] Other studies have documented similarly elevated PTSD rates among urban Latino

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[48] (B. J. Good, 1994)
[49] (Ortega & Rosenheck, 2000; Ruef, Litz, & Schlenger, 2000)

youth exposed to street violence, and among Latino police officers.[50] Some physicians and epidemiologists have attempted to explain these higher rates in terms of common Latin American cultural idioms of distress such as *ataque de nervios* or *susto*, both of which occur when acute stress or fright results in a dislocation between body, soul, and the social world – a phenomenon that bears a resemblance to biomedical definitions of trauma.[51] Such explanations, despite myriad anthropological warnings against essentializing culture and ethnicity in the clinical setting, have been put forward without nuanced analysis of how *ataque de nervios*, *susto*, or even PTSD are understood or experienced by Hispanic veterans.[52]

In an effort to address this gap, I regularly asked study participants about *susto* and *nervios* throughout the first half of the study.[53] I found only two study participants (an older Vietnam veteran married to a woman who grew up in Mexico and one Latina spouse from a South Texas border city) who had heard of *susto*, and neither of them thought it could apply to PTSD.[54] A local *curandero* I spoke with thought the *susto*/PTSD overlap could exist – that there might be grandmothers in the area offering to treat their veterans for *susto* – but said that he had heard no reports of anyone actually working such cures. After about a year of asking about

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[50] (Bremner & Brett, 1997; Pole, Best, Metzler, & Marmar, 2005; van der Kolk, et al., 1996)

[51] (e.g. Guarnaccia, Rivera, Franco, & Neighbors, 1996; G. N. Marshall & Orlando, 2002; Poss & Jezewski, 2002; Ruef, Litz, & Schlenger, 2000)

[52] (e.g. Kleinman, 1988b; A. J. Rubel & Garro, 1992)

[53] One of the goals of the PDS study was to use ethnographic analysis to move beyond epidemiological generalizations of "Euro-American" and "Hispanic" ethnicity and to better understand how individuals' experiences of trauma-related mental illness were informed by personal history, local constructions of ethnicity, and diverse and overlapping cultural discourses around health and the body (Abraida Lanza, Armbrister, Florez, & Aguirre, 2006; De Genova & Ramos-Zayas, 2003; Gaines, 2005; Santiago-Irizarry, 2001).

[54] The older Mexican-American Vietnam veteran referred to *susto* in the context of work he claimed to have done for the U.S. Drug Enforcement Agency in Mexico in the 1970s, which involved interrogating potential informants. The younger woman had heard of the folk illness *susto*, but only among children. When I asked whether her husband's PTSD might be related to something like *susto*, she demurred that no, he was an adult.

this, the looks I was receiving were consistently so blank that I concluded I was barking up the wrong tree and stopped asking. These findings should not be taken to suggest that no Mexican-American veterans living in San Antonio have ever experienced *susto*, and indeed, this question might well have found more traction among a population being interviewed in Spanish and outside the context of a biomedical clinic. What it does suggest is that Mexican-American veterans should not be *presumed* to utilize these idioms of distress, particularly in an area like South Texas, where the majority of Mexican-American families have lived in the U.S. for a number of generations and are subject to a wide variety of cultural influences.[55]

Another of the questions I pondered was the degree to which Latino veterans in San Antonio might seek help for war-related problems from one of the dozens of Latin American *herberias* (herbal shops) and *curanderos* (folk healers) located throughout the city. Although I did not pursue a systematic investigation of this issue, I did visit three randomly selected *herberias* along with the anthropologist Brian Bayles, whose own fieldwork has specialized in Mexican folk healing. [56] Several employees told us that they have sold protective Catholic medals to the mothers and grandmothers of service members heading overseas, and suggested several remedies that might be offered to troubled families. One local *curandera*, working out of her own shop, said that one young veteran comes to visit her almost daily. He has *trauma*, she said in Spanish, although he mostly just comes by to talk. Moreover, several of the VA clinicians told me that a few of their Latino patients had mentioned making visits to a local

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[55] A strong reliance on biomedical explanations for illness among San Antonio Mexican-Americans is consistent with anthropological research on pregnancy and birth, which has found that Latina women on both sides of the border share equally biomedical models of pregnancy (Fleuriet, 2009; Torres, 2005).

[56] I have, however, heard of several other anthropologists who may be pursuing this question in the San Antonio area, and I look forward to hearing from them.

Catholic shrine dedicated to healing. Nonetheless, among the 25 Latino veterans participating in the study, none reported seeking help from any source besides professional mental health care providers, or, in rare cases, their church. This pattern held for veterans of all other ethnicities in the study as well.[57]

Beyond the inadequacy of ethnicity-based predictions for what kind of care veterans might be seeking, it was also striking how many veterans (of all ethnicities) put off seeking care of any kind for the problems they were having, and the reasons they gave for this. Given the many problems that veterans have described thus far – the irritability, the nightmares, the sleeplessness, the disconnection from family and friends, the difficulty feeling at home in the civilian world – it seems reasonable to ask, why would they hesitate, sometimes for years, before seeking out some kind of external solution?

As it turns out, there are a variety of answers to this question, and each of them reveals something about the influence of cultural ideas on how people take action when faced with a problem, both in terms of how they identify *what the problem is*, and in terms of *what they deem to be an appropriate response*. Derek and Laticia, for example, responded to Derek's problems by recognizing how they interfered with family life (going to Six Flags, attending family events); looking for an explanation, they considered PTSD. When Derek found that his reactions were making it difficult to pursue his educational and career goals, he sought professional mental health care.

It is important to note, however, that Derek and Laticia were fairly well-informed about PTSD. Derek had spent months in inpatient and outpatient care at Brooke Army Medical Center

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[57] It is worth noting that veterans entered into this study largely through the VA and local universities, which may have biased the sample towards those individuals who identify strongly with biomedical care.

for the injury to his leg, and received education about PTSD symptoms as part of his regular care. Therefore, when his problems failed to go away over time and began to interfere with his life plan, he had a name on hand to give to the problem – PTSD – as well as a solution – seeking professional mental health care.

For those veterans who were not aware of PTSD and its symptoms, however, the situation could be less clear. One Army veteran named Miguel went in for a physical at the VA, filled out some questionnaires, and was told he had PTSD. He says, "I'd never heard of it. I was thinking, 'what is it?' I didn't know what the heck it was. I was oblivious as to what was actually wrong with me until I was told, 'this is what you're going through.'"

Others had very different ideas about what was happening to them. Chris, for example, never thought of his suicidal urges, his drinking, or his violent responses as PTSD-related; he thought he was depressed. Jesse was told at the emergency service that he was having panic attacks, and he took that to mean that panic attacks were the central problem. Both Chris and Jesse understood their problems as falling under the broad rubric of mental illness and sought out mental health care as a result. But for a surprising number of veterans, particularly those who went off to war in 2002 or 2003, PTSD was simply not on the radar. It had not yet been the focus of the media attention that came later, nor it was it something – yet – that the military was actively taking steps to educate its personnel about.

Veterans and family members who were unaware of PTSD, then, didn't always understand the phenomena they were experiencing as *symptoms* that were part of a larger *illness*. Brian – who was knowledgeable about PTSD from his years as a medic – says he first began to seek out information leading to treatment when he began having memory trouble and started missing important meetings at work. He also says that, "[O]ne of the things that tipped

me off was my wife said, 'You know what? You're an asshole.' I said, 'Why?' She said, 'You're mean. Why are you so mean?' I said, 'You think I'm *mean*?!'"

His wife wasn't saying to him, 'Gee, Honey, I think you have PTSD. I'm worried about you and I think you should go get help.' Instead she told him that he was an asshole, a statement which implied that he was behaving badly. In other words, she was not responding to something she perceived to be a *symptom*, she was responding to what she perceived to be a *behavior*. Brian is a medic, and PTSD was something he was already concerned about, and so he understood her comment as a tip-off about the possibility of PTSD. But she wasn't talking about PTSD (in fact, she remained quite skeptical about the idea of PTSD even after he was formally diagnosed). She was talking about how he was acting, and she wasn't happy about it. Where he saw symptoms, she saw behaviors. Where he saw illness, she saw asshole.

Their conflict reveals a gap that frequently emerged in the way that couples interviewed in this study spoke about PTSD. For while many of the post-deployment phenomena we have discussed may be thought of as PTSD symptoms, they also map onto a series of American cultural ideas about appropriate male behavior. For veterans and family members alike, this overlap can make the task of choosing how to respond to these problems all the more difficult. Chris' wife, for example, didn't respond to his drinking and his violence by suggesting that he go for medical evaluation. She left him – and their kids with him – and moved back to the U.S. Tony's friends didn't suggest he get help; they just stopped calling. How do we understand this?

In answering this question, it helps to take a step back and consider normative expectations for men in contemporary American life.

Gender and Stigma

On an overcast Sunday morning in 2007, I attended one of the mega-churches in San Antonio, pursuing the classic participant-observation strategy because I was curious to see how suffering might be talked about in local churches. I selected this particular church because several of the PDS study veterans had told me they worshipped there, and because I knew it had a large enough congregation that my presence was unlikely to be intrusive. A prominent white Southern evangelist was visiting that day, preaching a guest sermon for the several thousand men and women in attendance, and I was so struck by one of the stories he told that I sat out in my car after the service, writing frantically in an attempt to capture it as accurately as possible. What he said, roughly, was this.

He spoke about how other ministers sometimes ask him, 'Don't you ever struggle?' And he said, 'And when they ask that, they always mean two things: women and money.' He leaned forward and held a dramatic pause before going on. 'I don't see women as sexual objects to be conquered,' he said, and his voice gained in volume: 'They're not second-class citizens!' There was resounding applause from the women in the congregation, and he went on, 'And as for the women in my life, they control me and that's ok, because I like to be controlled. I've been controlled by women since the day I was born. My Mama controlled me, my wife controls me and my daughter controls me. That's just the way it is.' The gathered women gave another big round of applause. (I noticed he didn't say anything about the money part.)

He went on to describe the hosting preacher's family. 'And you should see how those grandbabies control their granddad. In the anteroom before the service, they're running around and he's stopping the conversation to play with them, and they're getting snot all over his shirt and that doesn't matter because that's what they're supposed to do. They're *supposed* to put

their care upon him.' He linked this to a Christian ideal of putting one's cares in the hands of God, then turned his commentary back into a story about when his daughter was in school and had trouble with the principal. He described going in to talk with the principal, and here he stood up straighter and his stance became suddenly tougher, his voice harder.

'So we have a problem. What are we going to do about it?'

'Well,' he said, voicing the principal, 'it's going to change.'

'That's right it's going to change. And if it doesn't change, that's ok because I live right near here.' He made a mock mafioso face and pronounced the classic Godfather line – 'I made him an offer he couldn't refuse.' He said, 'And I did this for my daughter because she has put her care upon me, and that's what I'm supposed to do is to take care of her. When she was little I told her to put her care upon me and now she's thirty-six and she still puts her care upon me. I was tough with that principal, but you don't touch someone I love. You *do not touch* someone I love. Sometimes a man just has to be a man. Am I right, men?' And the hundreds of gathered men, in their turn, shouted and clapped their hands.

The message was clear. Women were not to be treated as sexual objects and should have control over the household, but men were to look out for their families and take care of their loved ones, even if that meant being a little rough sometimes. The applause thundered forth.

There is a considerable literature – from across the social sciences – that deals with the social construction of gender roles in cultures around the world. In every society, there are cultural expectations that men and women will act within a range of certain specified behaviors, and these expectations are passed on to children through messages both subtle and direct. Boys may be shamed when they cry ('Don't be such a girl!'), and praised when they demonstrate

independence or risk-taking behaviors (or stand up for their families).[58] Dominant masculinity traits that have been identified among American men (which usually means young white men in college, the most frequent sampling pool in psychological research) include an emphasis on competitiveness and winning, a desire for dominance, a focus on self-reliance, a practiced control over emotion, and so on.[59]

In 2006, Matthew Jakupcak and his colleagues, clinicians working out of a VA in Seattle, published an article in which they pointed out that some PTSD symptoms seem to overlap with these traditional American expectations for masculine behavior, citing in particular the tendency towards social withdrawal and restricted emotionality.[60] What became clear in my conversations with veterans and their wives, however, was that in many cases veterans' post-deployment symptoms were being interpreted by family members within the realm of male behavior *rather than* within the realm of trauma-related illness. Further, they were being interpreted in terms of negative aspects of traditional masculinity, as not just male behaviors but as unacceptable male behaviors. So, at least from their partner's perspective, many of these men weren't viewed as being ill so much as they were viewed as – as Brian's wife so succinctly put it – being assholes.

In the realm of ordinary everyday life, there are abundant ways in which these disjointed viewpoints can run into conflict. A veteran experiencing anger and irritability might be told by a clinician that his symptoms indicate PTSD-related hyperarousal, but his girlfriend may see it very differently – as aggression, an unpleasant desire to control his surroundings, or

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[58] (Mahalik, et al., 2003)
[59] (Mahalik, et al., 2003; Tager & Good, 2005)
[60] (Jakupcak, Osborne, Michael, Cook, & McFall, 2006)

as an inability to control himself. A clinician might register a veteran's flattened emotional register and desire to isolate as evidence of numbing and withdrawal, but his wife may just wonder why he is being so distant, why he isn't romantic anymore. A veteran who is avoiding crowds at the grocery store or staying away from family events – as when Derek refused to accompany Laticia to her family's New Year's Eve party – could be seen as practicing avoidance, but he might also be seen as refusing to help out or being uncompromising and insensitive. An inability to hold down steady work may be viewed as a PTSD-related functional impairment, but it may also be seen as a failure to live up to cultural expectations that a husband and father will provide for his wife and children. One of the clinicians I interviewed pointed out this disjuncture, noting that men, in particular, may display irritability as an alternative to showing anxiety, and so veterans' avoidance may look very much like what she called 'macho withdrawal.'[61] Another clinician pointed out that, although she tries to make educating family members a part of the care she provides to veterans with PTSD, very few spouses will agree to visit the clinic because they don't give much credence to PTSD as the source of their husbands' problems: 'They just think they're plain angry mean people.'

Among the nine Iraq-era couples who participated in this study – meaning that both the veteran and the partner were available for an interview – nearly all had mismatches between veterans' post-deployment experiences and their partner's gendered expectations. In Chapter Three, Laurie described how Josh would yell at her "like one of his Marines" after he returned from his first deployment, which she found infuriating and unexpected because "usually the woman's the boss of the house." One veteran described days on which he begins ruminating

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[61] Irritability has also been discussed as an alternative to showing depressive symptoms among men (Magovcevic & Addis, 2005).

about events in Iraq and finds it impossible to get up off the couch and make it to the university for his classes; his live-in girlfriend described those dismissively as his "couch days" and complained about how he plays video games all day. One couple who was clearly still very affectionate – she kept her feet up in his lap throughout their interview – was struggling because he had become distant with her, short-tempered with their kids, and uninterested in their previously active sex life. He was failing to live up to her expectations of him as a husband, father, and lover.

Thus it was ideas both about illness – in particular, what constitutes a symptom as opposed to a behavior – and about male gender roles – the expectations placed upon men to behave as men – that were important in shaping family members' responses to a veteran's post-deployment struggles. Recognizing this, however, only gets us part of the way there. For, as is to be expected, there was considerable variation in the range of ideas about gender and illness expressed by men and women in the study.[62]

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[62] I also ran into a few situations that suggested some families may not be sure *what* to think. I received a call one afternoon from a woman who asked me, 'Is this about the depression thing...the E thing, or H, or I can't remember what it's called...my daughter's been deployed 3 times and she's having trouble with the transition to civilian life and she gave me this and told me to call you...' As she went on, it became clear that her daughter had seen the study flier at the VA and given my contact information to her mother, who called, hoping that I would be able to explain what was going on with her daughter. I told her that I was not a clinician, but that I was conducting research with recent veterans, and we talked for a few minutes. She told me that her daughter was a Marine who had deployed three times to Iraq. 'She'll be fine and then all of a sudden she's snapping at everybody...' When the opportunity for a fourth deployment came up, the daughter wanted to go, she said, 'But we all said 'what are you doing?' She said, 'But my family's over there.' We said, 'Well, what about your family here?' She says it's not the same.' I suggested some local resources for the family, but the woman seemed frustrated when she hung up. She was struggling to put a name to what her daughter was going through, and trying to find an explanation that made sense to her.

Even those families who were aware of PTSD as a possible category for explaining veterans' post-deployment struggles marshaled a wide variety of responses. Some wives, like Laticia, accepted PTSD as simply one of many things that can happen to service members in wartime, and saw it as something she and Derek needed to face together. Some family members researched PTSD online or in the medical literature, seeking to better understand the diagnosis. I asked a young veteran named Eric about his parents' reaction when he was diagnosed with PTSD and he answered that "they're sad that I had to go through it," then dived so quickly into another story that I was unable to ascertain whether he meant the war or the illness that followed it. Tony told his sister about his run-in with the Marine at work, about how it had opened up his memories of Iraq and left him feeling off-kilter and emotional. She cried for him, although once again it was not clear what piece of her brother's suffering caused her grief. Perhaps it was the sheer overwhelming whole of it. These family members saw PTSD, or even war-related suffering more generally, as an experience that called for understanding, the search for more information, or even sadness.

But this was not always the case. Mariana, the wife of a Vietnam veteran, described with horror how she had heard friends and neighbors speak about veterans who returned home from the recent wars with troubled minds. "Look, some people will say, mothers for instance, of these younger guys – and I see the looks on their son's faces – '*Por m'hijo, vino con PTSD* [my son came back with PTSD],'[63] and then the son's face just goes down and you see that. You see him recoil into his corner. And I want to grab the woman by the neck and say, 'Don't ever say those words again…'"

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[63] Initial translations were made by EF, and then checked for accuracy by Latin American scholars.

I asked her, "In what kind of a setting?"

"In a social setting." Mariana described sitting around in a family group, and how she had seen sons react to such public outing with a crestfallen face before getting up and making an early exit. She shook her head. "Or it'll be at a wedding, or it'll be at a family gathering, or it'll be like neighbors, across the fence - 'Oh, how's Dickie doing?' 'Oh, *m'hijo* came home and *pero ahí esta el baboso*.'" Unsure of my Spanish, she explained, "*M'hijo* [my son] came home with PTSD, but the asshole or the stupid idiot… *Baboso* means, you know, like idiot, stupid. *Baboso ahora, pero hay lo tengo*…like 'I got the idiot here in the house now. He's afraid to come out.'" That was the mothers, she said. The young wives were a whole other story. She dramatized asking, "Did he come back?" and the response: "'Oh yeah, that dude's a no good mama's boy – won't come out, just stays in his house.'" Mariana said her husband had to tell her to step back when she heard this, she got so angry. "And I'm going, 'This boy, this *man*,[64] went and fought a war for his country for your happy ass to come and be around here – and you're going to put him down?'"

Carlos told a story about sitting around the backyard with a fellow Iraq veteran and Army buddy, his friend Pepe, who began to cry as he described how hard he was finding it to put his life back together after the war. Pepe's wife came outside and, seeing him in tears, said – Carlos mimicked a disdainful voice and a curled lip - 'Don't be bringing that war shit in here. You didn't have it hard over there! I had it hard here taking care of the children, so don't be bringing that depression shit in here.' Carlos defended his friend by saying, 'Sometimes you need to cry.'

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[64] Emphasis in the original.

He compared the wife's reaction with the safe haven that other veterans can offer: 'Veterans are never judgmental about this, they understand.'

Revisiting the idea of social support discussed in the last chapter, it seems likely that such attitudes towards the expression of veterans' post-war grief and suffering can make it more challenging for some men to settle back into normal life. They may also make it more difficult to justify seeking care for what may be dismissed as problems of weakness or failed character, rather than signs of an illness of great suffering, by those around them.

Many veterans and their families, in fact, seemed to be aware of this danger, defending veterans close to them against the perceived dangers of what can happen when veterans are left without the support they need. Two of the veterans interviewed spoke about military buddies who have become homeless in the time since the end of their service, offering them up as cautionary tales. Brian has a friend who is homeless and who comes by the house sometimes. He is married, with "two beautiful kids," but Brian says, "He just can't keep it together, and his wife doesn't want him around because he's too switched on, he can't shut it off. And we'll talk, but he's perpetually drunk and he can't stop it." I heard similar stories from more than a few Vietnam veterans who called about participating in the study and, before they hung up, ended up telling me long stories about the years in which they went from the bottle to a divorce to the bottle to a new wife and a new divorce and on and on.[65]

This lesson of what can happen when a veteran falls through the cracks was one that some of those I met counted among the most painful legacies of the Vietnam War. A Vietnam

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[65] Because the focus of the study was intended to be OEF/OIF veterans, IRB approval was only requested for 5 Vietnam veterans to participate in the study. That quota was filled quite early in the study period, although I continued to receive frequent calls from Vietnam veterans who were interested in participating.

wife I met at the VA clinic told me about a young man she had known when she was a girl, back when, she said, they hadn't understood about PTSD. Everybody liked him, he was a big favorite. But then he went to Vietnam, and when he came back, he wasn't the same anymore. He walked down the street staring at the sidewalk. Her mother told her not to talk to him and said he was *loquito* [a little crazy]. Nearly forty years later, she leaned against the wall in the hallway where we were standing and said, 'That was ignorant, but we didn't know about PTSD then. So nobody talked to him, and eventually, you know, he committed suicide. He was all alone – he didn't get any support.' Her memory comes out like an irrevocable chain of events: there were attitudes that led to behaviors that led to an outcome.

I say "attitudes" because, as a general rule, anthropologists are less likely to talk about "ignorance" than about different understandings of a given phenomenon. Anthropology was founded on a notion of cultural relativism that has left many of its practitioners uncomfortable about assigning more authority to the perspectives of one group than another's. For example, I often fall back on referring to veterans post-deployment struggles as "difficulties" or "phenomena" rather than the more utilitarian "symptoms" because I am loathe to privilege the clinical perspective over veterans' own understanding of what is happening to them (at least until the veterans themselves begin to refer to their experiences as 'symptoms').

But by whatever name we call them, whether attitudes or beliefs, what emerges from this study is the observation that families forge their responses to post-deployment struggles in the context of what understandings they have about gender and postwar suffering – whether they see PTSD as an illness deserving support, an illness deserving of some disdain, or as a complex of behaviors that may interfere with the expectations they have for their veteran as a son, father, or husband.

Cowboys and Caballeros

Living amidst these understandings of illness and gender, surrounded by the intensely personal words, actions, and judgments of families and friends, individual veterans must themselves navigate a way to find the support they need while retaining an identity as a veteran and as a man that they can live with. In this way, veterans' own understandings of masculinity may also play a role in shaping their experience of PTSD and care-seeking.

Social scientists who study men and masculine identity around the world often speak of manhood as a state in which one must work to maintain one's manliness over time (one recent article was titled "Precarious Manhood").[66] This assertion is usually made in contrast with ideas about women, for in many cultures around the world, it is thought that women become women in a natural, biological process, without too much intervention.[67] Men, on the other hand, must be *made into men* as they mature, and must defend their masculinity across much of their lives. Vandello and colleagues have recently documented this thinking among college-age Americans; in a series of studies, they found that both men and women made assumptions based on the premise that manhood was a more slippery possession than womanhood, and that manliness was – to a greater degree than womanliness – dependent upon achieving certain social milestones, such as fathering children.[68]

The study of men and masculinity has been a topic of increasing interest through the social sciences over the past several decades, a growth stimulated by the widening impact of feminist theory and its attention to the place of gender in shaping the lives of both men and

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[66] (Vandello, Bosson, Cohen, Burnaford, & Weaver, 2008)
[67] (Gilmore, 1990)
[68] (Vandello, et al., 2008)

women.[69] This research has begun to examine, often with great richness, the way that men co-create their identities and their lives in relation to the expectations for masculine behavior and personhood that are valued by others in their social worlds, including their parents, their peers, their lovers, and so on.[70] This effort to maintain life and self as a man has bearing on men's efforts to manage experiences of illness and emotion as well, and may have direct implications for men's well-being, particularly when it affects how men identify and respond to physical and mental health problems. In the U.S., it has been widely recognized that many of the messages men receive – about self-reliance, for example – run into direct conflict with the need to reach out for help when injured or unwell, a finding that may help to explain why many men express reluctance to seek out healthcare or social support.[71] Ximena Mejia has described the essential features of American manhood as "toughness, fearlessness, and the denial of vulnerability" and suggests that these expectations may create unique challenges for men who have been exposed to trauma.[72] Men may find it difficult to identify with the idea of being traumatized (which can carry with it some implication of being a victim), may experience uncontrollable emotion as a threat to their sense of themselves as invulnerable and tough, and may – when at last they seek help – receive less empathy from those to whom they turn for solace and treatment.[73] (Thompson and Pleck offer the example of men being turned away from rape crisis centers after surviving sexual assault.)[74]

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[69] (Bourgois, 1996; Kimmel, Hearne, & Connell, 2005; Kimmel & Messner, 2003)
[70] (Brandes, 1980; Connell, 2005[1995]; Cornwall & Lindisfarne, 1994; Dunk, 1991; Eng, 2001; M. Gutmann, 1997a, 1997b; Gutmann, 2003)
[71] (Addis & Mahalik, 2003; G. E. Good, et al., 2006; Magovcevic & Addis, 2005)
[72] (Mejia, 2005)
[73] (Mejia, 2005)
[74] (E. H. Thompson & Pleck, 1986)

When I set out to conduct this research, therefore, I was interested in finding out more about how male OEF/OIF veterans understood their own masculinity, and whether this had any impact on their experiences of and responses to PTSD, which may represent its own kind of threat to precarious manhood. I have already described how PTSD may be stigmatizing, seen as a weakness of character. In addition, the type of post-deployment life impairments we've been discussing – such as failing relationships, the inability to hold a job, etc. – may be viewed as not living up to one's role as an adult American male. Given the somewhat increased risk of developing PTSD found among Latino veterans, I was also curious as to whether Latino veterans in the study would describe a sense of their own masculinity that was significantly different than that of Anglo veterans.

When Mexican-American or Latino men are the focus of scholarly discussion, their identity as men is often described in terms of *machismo*, a complex of masculine behaviors and attitudes widely held to be common across Latin America.[75] The literature on machismo has often cast it in fairly negative terms, emphasizing hypermasculine traits such as physical and emotional toughness, sexual jealousy, a stiff-necked and unbending aggressiveness, and the exercise of control over women (particularly over women's sexuality).[76] As Mexican-Americans and other Latinos have come to represent a larger and more influential percentage of the U.S. population, the word *macho* has slipped into common American usage, and *machismo* has become something of an American folk model for how Latin men behave. Alfredo Mirande has argued that, since this development, *macho* has come to have dual meanings.[77] When used to

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[75] Mirande (1997) has a useful chapter outlining the historical context of machismo in Mexican culture.
[76] (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008; Mirande, 1997)
[77] (Mirande, 1997: 66)

describe athletes and entertainers and other high-status individuals (of all ethnicities), it denotes strength, sex appeal, and a virile masculinity; in contrast, when used to describe the average Latino, it remains linked to stereotypes of male dominance, family violence, and patriarchy.

Machismo, in other words, is an idea that has considerable hold over the way that many Americans think about Latino men. Four of the clinicians I spoke with – three of whom were Latina – endorsed the role of a macho identity in shaping how Latino men respond to experiences of suffering and illness. One Puerto Rican clinician told me that, 'There's a macho image in our Hispanic patients and Mexican patients,' before elaborating on what this means to her: 'They're very resistant to showing they're vulnerable. They're tough, they're soldiers, they're not going to cry.'

For all the discussion of machos and machismo, however, I often found it difficult to bring the way that Latino men are commonly written and spoken about in line with my experience of living and working amidst men in San Antonio. This is an inconsistency that has been noted by other anthropologists as well. In the mid 1960s, Arthur Rubel wrote of his surprise upon visiting the homes of his young South Texas informants – who had complained at length about the gruff authoritarianism of their Mexican-American fathers – to find said fathers cradling infants and playing with small children, their suggestions and commands largely ignored by other family members.[78] Like Rubel, I encountered dozens of Latino men whose behavior belied the stereotypical macho image: speaking proudly about their role as primary care-giver for their children, laughing their way out of a potential confrontation, publicly and privately

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[78] (A. Rubel, 1966); Similar examples can be found in the ethnographic work of Matthew Gutmann (1996) and Mirandé (1997).

nurturing their wives. On the other hand, I had as many encounters with Texas Anglos, in particular, who presented themselves in greater accordance with it, demonstrating a marked hesitation to show emotion and bragging about incidents in which they had refused to back down from a confrontation. Talking with one (white, male) clinician about this, he described this phenomenon among white men as "the Bubba Syndrome,"[79] and acknowledged that both Latinos and whites can have difficulty accepting a diagnosis of PTSD because it doesn't "fit with the masculine stereotype." Even so, he hazarded that, "There's not as much as Bubba among white American males as there is machismo among Hispanic males. But even there, I think that – I'm no expert on machismo – but I think that it's not a homogenous factor either. I think that there's subcultures and there's family differences and it probably plays out differently from one individual to the next, even within the Hispanic culture."

The clinician called this local Anglo masculinity "The Bubba Syndrome," but one could also talk about "the Cowboy," the classic John Wayne or Clint Eastwood image of masculinity in the American West.[80] For anyone attending the two-week-long Rodeo that is held in San Antonio every February, it is impossible to ignore how cowboys in the ring – even those who have just been thrown or stomped on or beaten in the competition – largely refrain from giving any voluntary sign of emotion or pain, except perhaps a tight little wince or nod. R.W. Connell has rightly critiqued studies of masculinity that focus too intently on these kinds of idealized heros, arguing that they are unrealistic because so few individuals can ever hope to live up to

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[79] Although the clinician spoke of this term as a phrase that was commonly used, I have yet to encounter it in the psychological literature, online, or in other conversation.

[80] (Mejia, 2005)

them.[81] However, understanding what archetypes like the Cowboy represent can be helpful in illustrating how individuals construct their own gender identities in relation to such ideals.[82]

Still, observing the overlaps between these ideas about local masculinity – the Macho and the Cowboy – I struggled for a time with sorting out the practical differences between them. I admitted my confusion to a local service provider, Mr. Calderón, an older Latino veteran, saying, "I haven't been able to figure out how different [machismo] is from the white cowboy military type of manhood."

He answered, thoughtfully, "Pretty much the same, I think. I guess the difference – if I can individualize it – my Dad would always explain to us that being macho was not about fighting. It was about being a man and standing up to your obligations. And that was led by taking care of your family, being strong for your family, so that was a little twist. But you still, as part of that, yes, absolutely, you couldn't back down. So…it may be a little expansion of the cowboy mentality – going to the bar and you gotta be the biggest cowboy there." He laughed warmly. "And again, I say 'individualize' because maybe not everybody was taught the same lesson. But that was the way my Dad and I guess my other cousins, that's the way it was taught to us."

As though in answer to Mr. Calderon, scholars have drawn a more complex and nuanced portrait of Latin American masculinity over the past decade. They have argued that machismo is a rough trope inadequate to the complex reality of individual men's lives, and that machismo should be understood to include both positive and negative features.[83] Miguel Arciniega and his

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[81] (Connell, 2005[1995])
[82] (Townsend, 2002)
[83] (Arciniega, et al., 2008; Gutmann, 1996; M. Gutmann, 1997a, 1997b; Gutmann, 2003; Mirande, 1997)

colleagues recently proposed the term *caballerismo*, with its connotations of respectful chivalry, to refer to widely recognized positive aspects of Mexican and Mexican-American masculinity: nurturing behaviors, an emphasis on hard work and responsibility, protecting the family, spirituality, dignity, and emotional connectedness.[84] It should be noted that, although Anglo-American culture has a tendency to remain underexamined in the social sciences – whiteness too often being taken as the unremarkable norm – psychological studies among Euro-American men also tend to focus on aspects of maleness seen as negative because they may interfere with well-being and healthy relations with others. The well-regarded *Conformity to Masculine Norms Inventory* developed by J.R. Mahalik and colleagues identifies, among other prototypical features of Euro-American masculinity, competitiveness, control over one's emotions, risk-taking, violence, power over women, and a disdain for homosexuality.[85]

Despite this division in the way of speaking, both locally and in the literature, about Latino and Anglo masculinities, men in the PDS study demonstrated few ethnic differences in the expectations they held for themselves as men.[86] One portion of the survey that veterans completed was made up of a quantitative ranking measure derived from a free listing exercise conducted with the first ten men in the sample. During the early period of the study, veterans were asked to list their immediate responses to the question, *What are some of the most important expectations you have for yourself as a man?*[87] Participants were urged to suggest

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[84] (Arciniega, et al., 2008: 20)
[85] (Mahalik, et al., 2003)
[86] A nod to Connell's (2005[1995]) assertion that it is essential to avoid confusing what-men-do-as-men with masculinity as a trait that some men may have more of than others.
[87] If respondents were unclear about what they were being asked to talk about, I rephrased the question by asking them to talk about 'things you think you should do, or things you think you should be,' attempting to leave the field as open as possible.

five items, but most generally came up with two or three. After ten individuals had completed this free listing exercise, I developed a ranking scale based on their responses, and piloted this scale with the next several participants, who verified that it was clear and included all the most important concerns.[88] All remaining participants (40 men in all) completed the measure, ranking each of the suggested items in order of their importance.

Figure 4-1. Rank-Ordering Measure

Please rank the following in order of their importance to you as a man, from 1 (highest) to 9 (lowest):

_____ Being able to hold a job

_____ Being able to support myself/my family

_____Making my romantic/domestic partner happy

_____Taking care of my children

_____Maintaining friendships

_____Having an active sex life

_____Caring for my parents

_____Being a spiritual person

_____Maintaining my pride in myself

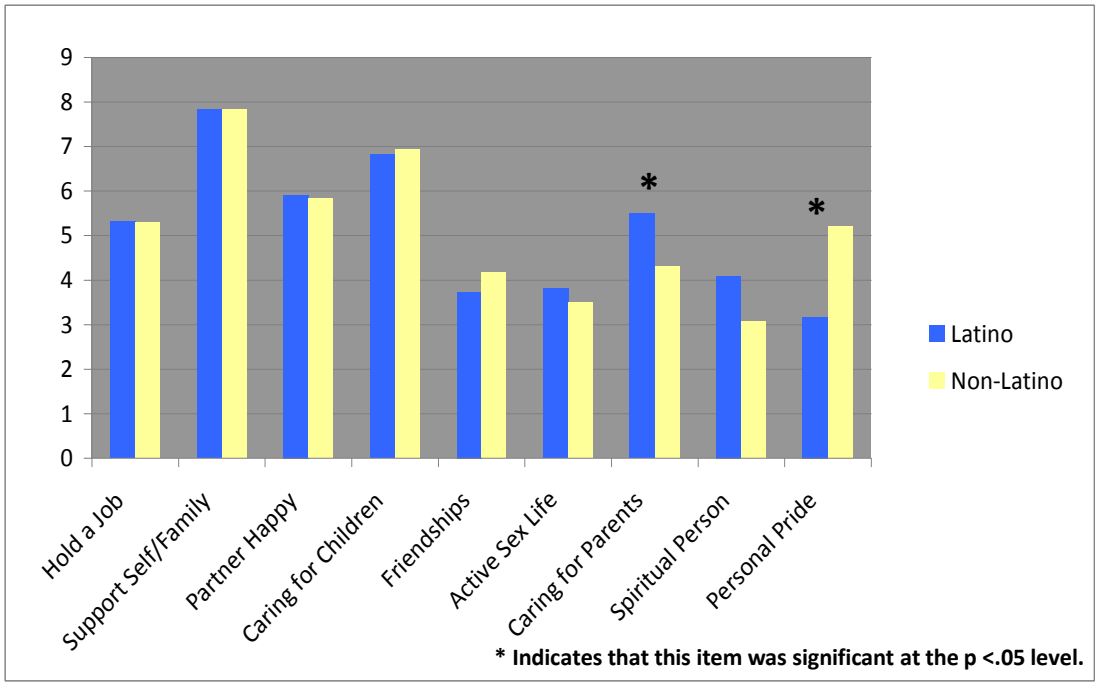
When the average ranking for each item was compared between Latino and non-Latino groups, there were only two variables on which there were significant differences by ethnicity (see Chart 4-2).[89] For one, men in the non-Latino group were significantly more likely to rate the importance of the item "Maintaining my pride in myself" as of a higher priority than were men in the Latino group. The second difference was that individuals in the Latino group were significantly more likely to rate

[88] The preliminary instrument was reviewed for face validity by members of my dissertation committee before piloting. The preliminary scale included eight items. The ninth – "Maintaining my pride in myself" – was suggested by the initial veteran with whom I piloted the exercise; his suggestion was endorsed as an important addition by the next several veterans interviewed and was included on the final scale.

[89] Those who read the description of the exercise closely will note that veterans were asked to rank their priorities in order of importance, from most important (#1) to least important (#9). Therefore, in the original data set, a lower mean score indicated an item was held to be more important by men in the group. On this chart, however, the data has been flipped so that the size of the bars would correspond visually with the importance of the item.

the importance of "Caring for my parents" higher than were non-Latinos. In other words, Latinos appeared to be more likely than non-Latinos to prioritize other items on the list above personal pride, particularly caring for their parents and being a spiritual person, although the latter of these did not achieve statistical significance.[90]

Chart 4-2. Ranked Priorities among OEF/OIF Male Veterans, by Ethnicity (n=40)



Looking at the data more closely, however, reveals that individuals within the groups varied quite a bit on their responses – some ranking "being able to hold a job" as of primary

[90] Study date included responses from 40 study participants for each of these items with one exception; because the final item, "Maintaining my pride in myself" was included later on, there were 32 responses for this item. Because the sample was not normally distributed, due to the higher frequency of PTSD-diagnosed than non-PTSD-diagnosed veterans in the PDS sample, Mann-Whitney was used to conduct all means comparisons. P-values for the differences between the Latino and non-Latino groups were 0.46 (2-tailed) on the "Caring for my parents" item, and 0.013 (2-tailed) on the "Maintaining my pride in myself" item.

importance, while others put this item in last place. There was nearly this great a range on every item. When lumped together into ethnic groups, these differences disappeared almost entirely, a finding that reinforces one of the great and too rarely asserted facts of any research around race or ethnicity in the U.S.: the difference between individuals is often far greater than the difference between groups.

Thus, the PDS data points to key *individual* differences in how Latino and non-Latino men have absorbed the messages and influences of their own social and cultural milieus, and in how these influences have shaped the expectations against which they measure themselves. An individual's ethnicity may, in some circumstances, provide a clue as to what cultural influences are most salient for that individual, but this does not work as a general assumption, particularly for those living amid the kind of a rich cultural mix that characterizes both San Antonio and the U.S. more broadly.

Table 4-3. Range in Priority Rankings among OEF/OIF Veterans, by Ethnicity (n=40)

Item	Range in Latino Group	Range in Non-Latino Group
Hold a Job	1-9	1-9
Support Self/Family	1-9	1-5
Partner Happy	1-7	1-8
Caring for Children	1-9	1-8
Friendships	2-9	1-9
Active Sex Life	4-8	1-9
Caring for Parents	2-9	3-9
Spiritual Person	1-9	3-9
Personal Pride	1-9	1-7

After completing the rank-ordering exercise, veterans were asked to rate their confidence in their own ability to complete each of the priority tasks: holding a job, making a

partner happy, caring for their children and parents, etc. For it is one thing to identify a task as important, but something very different to feel capable of living up to the task.

Once again, individual veterans who completed this exercise reported wide ranging levels of confidence in their own ability to live up to these self-expectations. Possible scores ranged from 9 (very low confidence) to 45 (the highest possible confidence). Veterans' responses ranged from 16 on the low end all the way up to 45. And yet again, these differences disappeared when the data was analyzed by ethnic group. There were no statistically significant differences in confidence levels between Latino and Non-Latino groups for any of the 9 items, nor were there significant differences in total confidence scores (see Table 4-4).

Table 4-4. Mean Confidence in Ability to Fulfill Priority Tasks by Ethnicity, OEF/OIF Male Veterans (n=40)

Item	Latino Group	Non-Latino Group	p-value*
Hold a Job	3.73	3.89	.848
Support Self/Family	3.73	4.05	.388
Partner Happy	3.41	3.32	.694
Caring for Children	3.90	3.67	.538
Friendships	3.59	3.42	.524
Active Sex Life	3.32	3.58	.747
Caring for Parents	3.95	3.37	.199
Spiritual Person	3.59	3.21	.525
Personal Pride	3.83	3.80	.493
Total Confidence Score	33.94	34.14	.720

***Note on interpreting this table:** The p-value is a statistical measure of significance. It is a convention that the difference between two means is statistically significant if the p-value falls below .05 or .01. As you can see, none of these scores indicate a statistically significant result. In other words, there were no significant differences in mean confidence level related to specific priority tasks between Latino and non-Latino groups.

Nonetheless, these confidence levels were important. Examining confidence scores in relation to veterans' reported symptoms of PTSD, depression, and anxiety revealed strong inverse correlations (see Table 4-5). On average, a veteran who expressed a high level of

confidence in his ability to live up to his gendered expectations of self was more likely to report low levels of psychological distress, across all types of symptoms. And vice versa: Veterans who lacked confidence in their ability to perform the priority tasks were more likely to report significantly higher levels of psychological distress.

Taking the analysis one step further, particular items on the confidence scale were individually associated with current PTSD symptoms, while others were not (see Table 4-6). The items that stood out as most strongly correlated with PTSD? Having confidence in one's own ability to hold a job, to support oneself or family, to make one's domestic or romantic partner happy, to maintain friendships, to keep an active sex life, and to maintain one's pride in oneself. All of these items were inversely correlated with current PTSD distress, suggesting that these tasks may present a particular concern or challenge for veterans with PTSD.

Table 4-5. Correlations between Total Confidence in Ability to Fulfill Priority Tasks and Reported Distress, OEF/OIF Male Veterans (n=40)

	Correlation with Total Confidence Score[91]	p-value
PCL-M Score (PTSD symptoms)	-.469*	.010
Hopkins-25 Anxiety Scale	-.698**	.000
Hopkins-25 Depression Scale	-.725**	.000
Hopkins-25 Total Score	-.754**	.000

* Indicates a finding significant at the p < .05 level.
**Indicates a finding significant at the p<.01 level.

[91] Since data were not normally distributed, all correlations were conducted using Spearman's rho.

Of course, statistical correlations are useful because they can reveal a possible relationship between two variables, but they tell us nothing about the causality behind that relationship. These data cannot tell us whether distressed veterans were experiencing psychological distress because they felt unable to fulfill essential goals for themselves as adult men, or whether they felt unequal to this task because they were experiencing psychological distress. It seems likely that there may be some continuing relationship between these feelings – the sort of vicious cycle we discussed with the social support data in Chapter Three. Perhaps high levels of emotional distress interfere with the ability to function in the realm of important life tasks. Perhaps the inability to live up to one's own expectations creates significant distress. Further research will be necessary to sort out whether these relationships hold up under additional study, and if so, to better understand how post-deployment suffering is intertwined with gendered expectations of self and the ability to satisfy them.[92]

But the PDS data also suggests a relationship between continuing social support and the veteran's ability to live up to his expected male role despite experiencing PTSD symptoms. Veterans who reported feeling less confident in their ability to fulfill core tasks, who were

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[92] The limitations of this exercise, though considerable, are helpful in that they provide an example of some of more common limitations of epidemiological research generally. For example, there isn't really any such thing – in the social categories of American life, anyway - as a "Non-Latino" person. This is a made-up category that was inserted for the purpose of being able to make broad generalizations about the men in this study, much like the terms "Hispanic" and "Latino" were created as a means of classifying peoples from all over Latin America, despite the extraordinary differences in class, skin color, ethnic identity, and even language among them. In addition, conducting statistical analysis on differences between these two groups requires ignoring many of the nuances of identity that emerge when veterans explain their own ethnic identities. For example, what about men like Jesse, who is half German-American and half Mexican-American? Or Derek, who is half-white and half-black? How should they be categorized?

struggling to live up to what was expected of them, also reported *receiving less social support from those around them*.[93]

Table 4-6. Correlations between Confidence in Ability to Fulfill Specific Priority Tasks and Reported Distress, OEF/OIF Male Veterans (n=40)

	Correlation with Total PTSD Distress Score[94]	p-value
Hold a Job[95]	-.660**	.000
Support Self/Family	-.503**	.001
Making Romantic/Domestic Partner Happy	-.532**	.000
Taking Care of My Children	-.288	.084
Maintaining Friendships	-.497**	.001
Having an Active Sex Life	-.388*	.015
Caring for My Parents	-.078	.639
Being a Spiritual Person	-.258	.113
Maintaining Pride in Self	-.493**	.005

* Indicates a finding significant at the p < .05 level.
**Indicates a finding significant at the p<.01 level.

Ethnographically, this relationship emerged in stories like Chris'. Shocked by the changes in him after his time in Afghanistan, his wife left him. Her departure seemed to steepen his downhill slide and he began drinking more heavily, ultimately becoming suicidal. When his distress came to the attention of his supervisors, he was held for a month in a psychiatric ward and given an early retirement, resulting in the loss of his planned military career. As his losses mounted, he fell deeper and deeper into despair. Describing this period, he says, "After a while

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[93] This was reinforced by another item on the WHO Disability Scale, in which veterans rated how much difficulty they had had in taking care of their household responsibilities over the previous 30 days. As with the confidence measure, veterans who reported more difficulty in being able to complete their household responsibilities also reported less social support, and vice versa. There was a significant correlation between confidence in the ability to complete key tasks and post-deployment social support (.556, p=.002).

[94] Since data were not normally distributed, correlations were conducted using Spearman's rho.

I was like, forget this, I don't have to take my medication anymore. I don't have PTSD. I was just depressed because my wife left me. My career is over and I have no money. That's when I had the second suicide attempt."

We continued talking, and later on I asked him how his wife – with whom he had reunited – was responding to the whole idea of PTSD. He answered, "She's one of those that doesn't get it. She's said things in the past like, 'You need to get hold of yourself. You need to just get over it.'…And the few times I've tried to reach out to her, because I've made mistakes… I haven't always been there for her and at times I've not been the best husband, either emotionally detached or physically separated. I think she thinks [PTSD] is something that I may use as an excuse….I don't know if we'll ever be on the same page about that."

Chris' wife remained noncommittal about his PTSD diagnosis and thought he used it as an excuse for the other ways in which he let her down. He, in turn, acknowledged that he had not always lived up to either of their ideas of a good husband – had not always been present, either emotionally or physically, when she needed him. He seemed to be drawing on almost a model of relational exchange as he spoke; as though, because he had not lived up to her expectations, he should not be particularly surprised to find that she was impatient with his PTSD.

In contrast, positive social support and even the need to live up to one's role expectations could also provide the impetus to work towards healing. I asked Laticia's husband, Derek, "Is there anything or anyone that has particularly helped you through this period of your life?" He answered, pointing at Laticia where she sat beside him, "I couldn't have done it without her. No way. Not at all."

"What'd she do that was so great?"

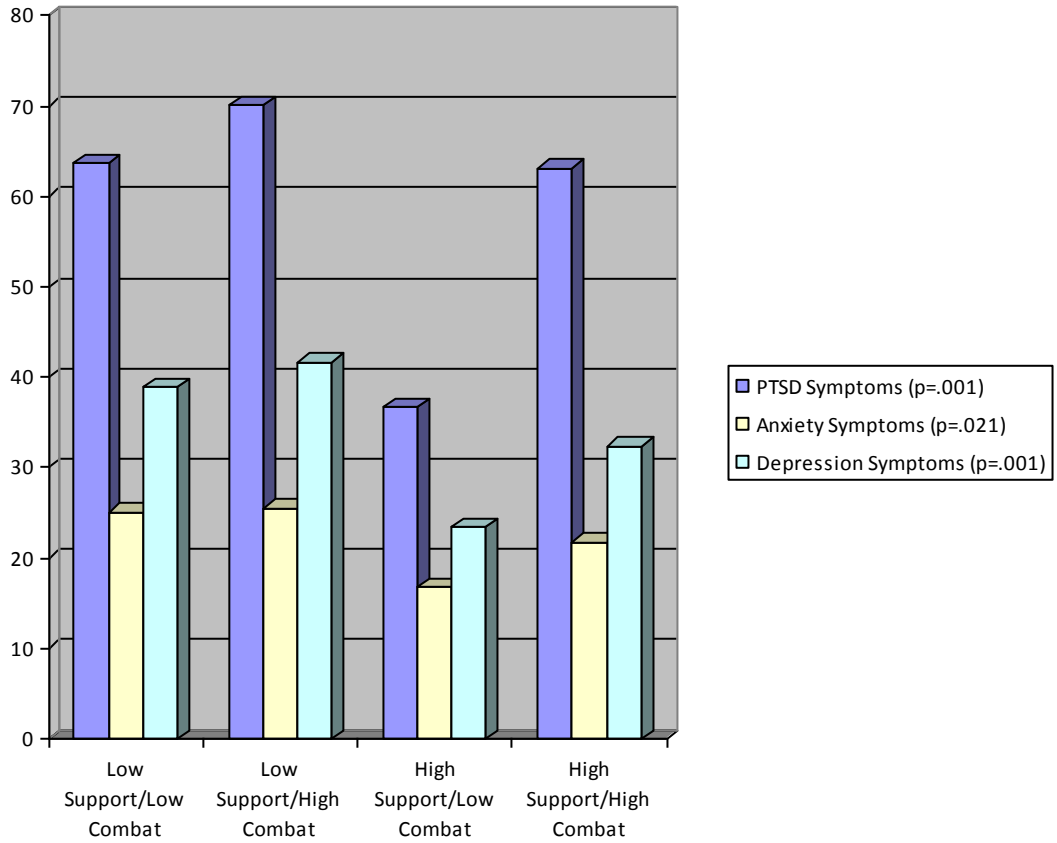
"She was my counselor, my financial advisor, she managed everything while I was too doped up to do anything….There's just the support, and comfort to know she was there….There's no way. And it's not just me. I have a family to take care of and support, so I can't sit there and feel sorry for myself. I never had the chance to just sit there and 'why did this happen to me?' It happened. You can't go back and change it, now we just figure out how do we take the best care of everyone. And that was just the process."

Derek's narrative describes how Laticia provided both practical and emotional support during his period of greatest distress, serving as his counselor and financial manager as well as his wife and partner. His story also points to another potential role for social support. Not only is there an apparent gap left when social support is absent, but where such support is present, it may have some capacity for providing a *protective* effect, helping veterans to maintain their resilience in the aftermath of combat trauma.

This protective effect seems to be borne out in the survey data. For the purpose of analysis, OEF/OIF veterans in the study were split into groups based on whether they experienced relatively more or less combat exposure during their deployments, creating a High Combat Exposure group and a Low Combat Exposure group. Veterans were then split once more into groups reporting relatively higher or lower levels of social support in the period of time following their deployments. This created four groups within the study: 1) a High Combat Exposure and High Social Support group; 2) a Low Combat Exposure and High Social Support group; 3) a High Combat Exposure and Low Social Support Group; and 4) a Low Combat Exposure and Low Social Support Group. Each of these groups was then compared for their level of current psychological distress based on reported PTSD, depression, and anxiety symptoms (see Chart 4-6).

The analysis revealed that those veterans who experienced high levels of combat exposure also reported higher levels of current distress; this is not surprising, given the known relationship between trauma and distress.[96] In addition, veterans who reported low levels of social support also reported higher levels of current distress; this is not surprising either, given long-standing recognition of the complex relationship between social support and distress.

Chart 4-7. Combat Exposure and Social Support among OEF/OIF Male Veterans, n=40



What was perhaps surprising was how clearly the results pointed to a *protective effect* of high social support against PTSD among those who experienced lower levels of combat. For those

[96] Because data was not normally distributed, analysis of variance was conducted using the Kruskal Wallis test.

who were exposed to more combat, receiving a lot of social support was not enough to protect them against negative mental health consequences. Even the amount of love and support shown by Laticia, for example, could not save Derek from developing PTSD, given his high level of exposure to combat. However, for those who were exposed to relatively *little* combat, a lot of social support could be very protective indeed, with the Low Combat/High Support group showing significantly less severe PTSD, depression, and anxiety symptoms than those in any other group.

This research suggests a new mechanism by which the severity of PTSD and other psychological distress may influence the amount of social support provided by partners and other families, by interfering with veterans' ability to adequately perform their adult male roles. In other words, the social support veterans receive may be – at least in part – dependent on their living up to certain cultural expectations. When they fail to do so, social support may dwindle. When support dwindles, veterans may begin to experience increased distress. With increased distress may come increased difficulty in living up to cultural expectations, which in turn may further decrease the availability of social support. Yet again, a vicious cycle.

Dick-Swinging and Other Obligations

Having noted this tangle between social support, views of local masculinity and psychological distress, it is helpful to offer a few brief examples of how veterans with PTSD were attempting to maintain a sense of themselves as men despite the negative views of PTSD they sometimes encountered from family members. When necessary, many of these men took direct or indirect action to reassert a threatened identity.

Shortly after Tony was attacked and left "with a face like Frankenstein," he went out one night and beat another guy up. He says, "I wasn't looking for it. He punched my buddy and I went over there and got into it, and lost control and we fought. But I think it was my subconscious reacting, trying to make myself feel more like a man again, not so down. I had to redeem myself somehow." Having been physically dominated, he felt the need to reinstate himself as someone with physical power and the capacity to use it.

He also had his own stories of negotiating a downbeat reception from family members. Tony felt that he had no one at home who might understand PTSD in a way that didn't challenge his sense of himself. "There are some people who are like, 'Oh, PTSD is just because you're weak. Or it's because you're not mentally strong. You can't take it.' 'No, that's not it,'" he responded, 'because I am [strong].'"

I asked him who would say such a thing to him, and he answered, "They wouldn't say it to me personally. They would just say it talking about PTSD. Because no one knows [that I have PTSD]. Not very many people know that I come to these meetings or whatever for PTSD. People ask me, 'You alright? You know, because I hear a lot of people, they come from Iraq or Afghanistan and have that PTSD stuff, all that stuff.' I go, 'Well I'm fine.'" Then he has a little speech he likes to give those who ask, saying that, "People have PTSD, but it doesn't have to affect their whole lives. Some people are worse than others – maybe it's what they saw, or maybe they just handle it in a different way. Or they just haven't been able to open – they haven't had anyone to talk to. So if you know someone who has PTSD or you know someone that's having a hard time because they don't want to have help, you probably should tell them to go get help." He resists the characterization of those with PTSD as weak, and, channeling his

former role as a Marine sergeant, encourages those who ask him about PTSD to look out for others who might be in need of extra support.

Jesse has had a different experience. He said that his girlfriend, who told him that she read about PTSD in her training as a veterinary technician, thinks he's crazy. "She thinks I'm going to get scared and try to kill her or something. A lot of people have that idea, honestly." He also talked about his girlfriend's family, who "think that because they've had some life experiences – 'Oh, I've seen my friend killed' or 'I've been in a car accident' – that that's like what I've been through. [They say] 'You need to just get over it' and tell everybody that I'm weak about it."[97] This enrages him. "How in the hell is seeing your friend get killed like seeing somebody get blown up or seeing somebody's body who's been blown up or carrying body parts around? Or getting shot at? Or getting mortared? When's the last time somebody shot a rocket at you on the West Side?" He stops, takes a breath. "But there's starting to be an abundance of experts in this field [PTSD], walking around San Antonio. They think they know everything."

"So what do people say?"

"'You can get over this. It's all in your head, all in your head.' And I used to think that too, honestly. Until it's in mine!"

"What do they know?"

"I wish I knew! I wish I knew what their sources were coming from. I guess they just are afraid of the unfamiliar and they want to assume it's like something they've seen on TV."

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[97] From a clinical point of view, of course, all of these events have the potential to be traumatic. I suspect some of Jesse's dismissal of these non-combat events may be a result of his frustration that he's being told to just "get over it", although his dismissal also fits into a larger discourse among veterans on how impossible it is to understand combat unless you've been there.

It didn't seem like a coincidence, however, that Jesse went straight from telling me this into a story about one particular member of his girlfriend's family, a cousin who served in the Navy and who gives him a hard time whenever they run into each other, testing Jesse on his rank and his experiences in Iraq. "He always tries to make himself – he's one of these people who seems like he's so unhappy with his life that he's got to flaunt what he has to make himself feel better. He's got beautiful – he's got two kids, he's got a wife, and a house, and he's got a job. And – but he's always got to be, 'I've got this big TV! And I've got this car, and this truck, and what do you have?'" When faced with the cousin's challenge, Jesse replies wryly, conscious of the contrast. "'I have an apartment. I have a truck.'" He goes on, roused. "I love that. He always tries to do this shit with his medals, show me his medals. I'm like, 'I'll show you mine. You want to play this - swinging contest.'"

This juxtaposition of stories – the discussion of his family's idea of PTSD as weakness followed by the tale of an ongoing rivalry over personal accomplishments – seems to suggest that Jesse is weighing the accusation of personal weakness as an attack on his masculinity. He seemed to be tacitly admitting that the stigma associated with PTSD represents a challenge to his sense of himself as a successful man. Certainly, he is very clear in this story about what he felt he had over his girlfriend's cousin vs. what the cousin had over him. Jesse had more time on the ground in Iraq to serve as evidence of his toughness, and higher rank as evidence of his military success. The cousin, however, had a number of things that Jesse could envy as life successes: marriage, fatherhood, owning a home, the accumulation of cars and a big TV. These

are fairly standard American mileposts for judging the success of men's lives,[98] and Jesse, like many service members on the back end of long deployments, was behind in the race. Jesse himself acknowledged that this was a conflict over proving manliness, a "dick-swinging contest" (with the reference to male anatomy presumably edited out in a nod towards me), and ended this anecdote by pointing out that he could "beat the hell out of that guy."

Chris navigated his own discomfort with having PTSD in a more subtle way, by allowing others to believe, without ever actively making the claim, that he had been wounded in battle. Whereas a physical wound seemed to indicate, to his mind, the kind of combat service that he could be proud of, a psychological wound left him feeling vulnerable and ashamed. He admitted freely that this feeling was "really vain and completely self-indulgent", but spoke of how easy (and tempting) it was to leave people with the wrong impression about his reasons for leaving the military. "[M]y parents know that I was in the hospital, and that I was in the psychiatric ward. Family members – I don't know how much people know. But when somebody asks you, 'Oh, you were in the military. How long?' 'Twelve years. Well, I was medically retired.' 'Why?'" Left with the unwanted question hanging in the air, he remained unsure how to answer, uncomfortable with either the truth or a lie, and so he settled on a compromise. "'Yeah, as a result of Afghanistan.' I don't want to come out and tell them [it was PTSD] because of pride. I

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[98] As a point of comparison, Townsend's (2002) work on American cultural norms for (non-military) men's life trajectories elicited a general model, based on interviews collected from both men and women:

> The basic ordering of events [is] for a man is to complete an education, to get a job, to move out of his parents' home and live independently, to date a number of women, to meet the woman he wants to marry, to spend time as a couple, to set up home together, to buy a house, and to have children. (38)

His findings also demonstrate how individual men evaluate their own success *as men* in relation to their (in)ability to meet and maintain the normative gold standard.

don't know what it is. And they make the assumption that I was wounded somehow. And if they ask me I correct them immediately, but I've found through the grapevine that people come back and ask, 'Where were you wounded?'" He cannot make himself lie, nor can he fully own up to the idea of intentionally letting people believe he was wounded, but even so, he finds it hard to claim his suffering was more than simply 'a result of Afghanistan.'

While the experience of having to admit weakness and vulnerability could be profoundly discomforting for these men, their role requirements as men could also be – in line with Mr. Calderón's comment on the importance of standing up to one's obligations – a source of motion towards more active self-care. Derek sought professional help when he was unable to pursue his career goals. Adam, who admitted that much of the time he wants nothing more than for his wife to leave him alone, also acknowledged that, as a husband, he has a responsibility to her. "With marriage, it's not just me fighting, it's her fighting too. As much as I don't want to admit that, sometimes, or realize it, or acknowledge it, because I'm fighting my own struggles." For Tony, it was this obligation to his live-in girlfriend that ultimately drove him to seek care. "I never thought I was fine – I just didn't think about it. And then when it got to the point where it was just like – I think what happened was my relationship, I was like, 'I need to figure out what's going on here, because I'm trying to make something work and it's not working and it might be PTSD. So I'm going to go check it out."

Summing Up

In this chapter, I have attempted to draw out several points.

First of all, among the men in the study, there was more than one pathway to seeking treatment for post-deployment mental or emotional problems. Functional deterioration to the

point of reaching a crisis was one pathway. A slower and less dramatic decline, in which events accumulated until the veteran decided there was a problem requiring professional expertise, was another. (There are several other pathways to care-seeking worthy of mention; we will explore these in future chapters.)

Second, spouses, girlfriends, and other family members play an important role in helping to shape veterans' experience of post-deployment phenomena, both through the interpretations they offer of it – PTSD, depression, asshole – and through the responses they suggest. There did seem to be some evidence for variation in the type of help-seeking recommended by families across San Antonio – religious counseling or visits to local shrines, seeking out herbal cures or a *curandera*, etc. – but among the veterans and family members in the PDS study, help-seeking overwhelmingly referred to seeking professional mental health care, and this almost exclusively at the VA (where health care for service-related health conditions is free or low-cost, as I will discuss in Chapter Six).

What also became clear over the course of the study was that family members were only likely to encourage care-seeking if they understood the underlying problem to be one related to a mental or emotional disturbance. If the underlying problem was judged to be one of character ('you're mean!') or weakness ('it's all in your head!') rather than traumatic illness, the reaction might be very different. Even among families who accepted the veteran's problems as stemming from PTSD, responses ranged widely and were influenced by their understandings of PTSD and the amount of stigma they associated with the diagnosis. Families' responses to troubled veterans also seemed to rely heavily on their gendered expectations for veterans' behavior as men fulfilling specific adult roles, whether as sons, lovers, husbands, fathers, etc. Conflict seemed to arise where men found themselves unable to live up to those expectations.

Appreciating the power of these gendered expectations, I began this study with the hypothesis that there may be some cultural differences in the expectations that Latinos and Anglos have for themselves as men, and that these expectations might influence 1) their experiences of PTSD as more or less distressing, and 2) how they go about responding to PTSD – in terms of seeking or delaying the search for professional care, etc. What emerged, however, was the finding that any differences between Latino and non-Latino groups were less significant than the variation to be found among individual veterans. With the exception of the greater value placed by non-Latino veterans on maintaining personal pride, and by Latino veterans on caring for parents, there were no statistically significant ethnic differences in men's ranking of life priorities. This was consistent with analysis of the interview data, which indicated a wide array of individual understandings of masculinity and PTSD, as well as much creativity in managing and making sense of the illness. This is not to say that ethnicity has no place in shaping these veterans' experiences of traumatic illness, but only to say that, for this group of men, cultural variations in constructions of masculinity seem to be more nuanced than often supposed. Far greater than any ethnic variation was the variation introduced by men's individual ways of seeing the world, of viewing (and standing up to) their obligations as men, and of navigating amidst the complex and confusing messages that family members put forth about their suffering, whether they called it PTSD or some other name.

The PDS study also suggests that the perceived ability to perform key male roles was inversely correlated with levels of current distress, and directly correlated with levels of social support. While the retrospective, cross-sectional design of this study does not allow for making grand assertions about the relationship between these concerns, the ethnographic data does suggest that there may be an important connection between post-deployment distress, the

social support that veterans received from their partners and family members, and their ability to perform within the range of local expectations for adult men. Veterans whose symptoms begin to interfere with their ability to fulfill such gendered expectations may see both an increase in their own psychological distress and a reduction in the social support provided by others (just, of course, when they need it most).

Finally, although local understandings of gender and war-related suffering were critically important in forming the cultural backdrop against which veterans found themselves living with PTSD, we should not underestimate the individuality of each man's experience. Each of these veterans described his own way of viewing and standing up to his obligations as a man, and of making sense of his PTSD amidst the complex messages that family members put forth about his suffering. So while local constructions of gender and illness were important factors shaping veteran's experiences of PTSD, veterans retained the capacity to exercise considerable agency and creativity in managing their distress, a theme I will return to in Chapter Nine.

In the next chapter, we will continue to consider how cultural environment may impact the messages a veteran receives about PTSD, and the responses he may run into when dealing with post-deployment distress. In switching settings, we will also have the chance to further explore how cultural expectations around masculinity influence experiences of PTSD and care-seeking, by turning away from constructions of ethnic difference and toward what all these men had in common: life in the U.S. military.

Under Pressure

Military Socialization and Stigma

Chapter Five

"When I got back [from Afghanistan]," Chris says, "there was not even so much as a briefing that said, 'Let us know if you're having problems.' There wasn't so much as a number. There was literally nothing." It was early in the post 9/11 era, the spring of 2002, and the American military machine was far from having mustered the full might it would in the coming years. This may be part of why Chris's transfer received so little attention. And then there were the circumstances of his redeployment. "I was pretty much sent out of country because I – I injured a prisoner, pretty severely. And broke his arm."

He explains that he was not equipped to handle the routine prisoner transfer he was overseeing that day, and lost control when the prisoner resisted. He does not remember the event itself, although he is clear on the response by his chain of command. "It was pretty much, 'Maybe you need to go home, and we'll send you to Korea.' That's kind of the humorous part about it, and I look back and kinda laugh because I remember this major looking at me and saying, 'You're too fucked up for this war.' I was like, 'What do you want? Do you want killers? Do you want – and if I'm too fucked up for this place, why are you sending me home?'"

What began as a violent outburst deteriorated in a by-now-familiar pattern: family problems, violence, substance abuse, suicidal thoughts. "Obviously, because of the way I went home, they don't want anybody knowing about that stuff. So it's not like anybody pinned a note to the back of my shirt and said, 'Hey, this guy's pretty messed up. He just messed up a prisoner pretty bad. Maybe you should take a look at him.' Their answer was just to get me out of an area where there was loaded guns." Chris and another friend got orders to Korea almost immediately. "We were shipped off to a place where it's really easy to get alcohol and we got into a lot of trouble there. And it was just a downward spiral from there, for the next year."

He was arrested six times in Korea. When I asked if he would get in trouble, he scoffed, "Not only would I not get in trouble, I was the only one who would not get in trouble. They said, 'Ah, he's a combat vet. He's got all these medals – we don't mess with him. It's just Chris.' And those were the times I got arrested, and by the Korean police, not the base police. These were international incidents. And those weren't the countless other times I was jumping off of buildings and climbing water towers naked and all these desperate cries for help, these psychotic things that were out of control. And not only would I not get in trouble, I would get a pat on the back. 'You're crazy, man, you're crazy!' And for a year I was like that, and nobody ever stepped in."

The question is, of course, why – within the closely monitored social world of the military – Chris' downward spiral was allowed to continue unchecked for so long. And not only Chris, but others in his unit as well. "A good friend of mine killed his wife and then himself. And then another one killed himself and one other person, I think it was his wife's lover – I'm not positive on that. And just recently another friend of mine killed himself, and the war's been long over for him. He was medically retired for emotional imbalance, too, like myself, about the

same time. That's three people out of fifteen. Probably half of that group is either out of the military or dead. Two others were killed in Iraq. It's like the wheels fell off that group."

Chris acknowledges that, when he finally became suicidal, it was his military leadership who stepped in and made the intervention that probably saved his life. But that was in 2005, some three years after he was sent home from Afghanistan, years in which his life had continued to escalate out of control, in which he was less of a husband to his wife, less of a father to his children, and in which he slowly knocked himself out of the running for the military career he had always wanted. The question is, why did it take so long for the military to recognize that Chris was falling apart?

Taking a closer look at this question reveals a deep ambiguity at the heart of how service members experience combat stress while still in the military. This ambiguity stems from both the scenario itself – in which those who are supposed to be the toughest of the tough find themselves beginning to show signs of strain – and from individual efforts to navigate amidst a maelstrom of confused messages about illness, gender, and the covenants of military life. In order to understand this ambiguity, it helps to consider the social and structural pressures placed on the American military as a contemporary institution, exploring how these pressures have encouraged certain cultural and organizational responses to combat stress over time. In this chapter, I examine these pressures and provide a broad overview of how the U.S. military has attempted to negotiate them, and with what impact on the lives of individual service members.

I begin with the early years of the Global War on Terror, and the role of the American media in bringing combat stress and its consequences to the forefront of national attention.

Public Outcry (Media Pressure)

The first American military scandal of the post-9/11 world occurred in the summer of 2002, when four Ft. Bragg military wives were killed by their husbands in the space of six weeks. Three of the four men implicated in the killings had recently returned from Afghanistan, and the media coverage immediately honed in on the question of whether these killings were related to their deployments. Within days of the story breaking, CNN.com posted an article suggesting that the killings "have led commanders to take a new look at whether combat deployments may be causing undue stress."[1]

The summer of 2002 marked the first increase in the media coverage about combat PTSD in the American military since the 1991 Gulf War. After this bump, there was another during the early invasion into Iraq in 2003, and then the amount of media attention paid to PTSD seemed to lessen slightly, although the topic re-emerged periodically amidst coverage of the war.[2] In November 2006, another story hit the news, this time centering around Sergeant Georg-Andreas Pogany, who was formally charged with "cowardly conduct as a result of fear" after he sought help from his leadership in Iraq for what he described as a panic attack.[3] The

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[1] (Starr, 2002)

[2] A LexisNexis Academic search of newspaper articles containing the words "post-traumatic stress disorder" among Major U.S. and World newspapers found 83 articles in 2002, 90 articles in 2003, 69 in 2004, 66 in 2005, 82 in 2006, 97 in 2007, and 197 in 2008.

[3] (Gettleman, 2003); Pogany, now 33 years old, worked in intelligence and was deployed to serve with a Special Forces unit in September 2003. On his second night in Iraq, a nearby U.S. patrol was ambushed and returned to the compound with Iraqi prisoners and several wounded. Pogany heard the trucks pulling in and left his bedroom to find a disarray of ambulances, Humvees, and people screaming. Smelling blood, he looked down and saw a body bag, which two men opened to reveal the corpse of an Iraqi man whose torso had been torn apart by gunfire. Nearby were five handcuffed Iraqi prisoners, one with a severe leg wound, and a young U.S. soldier sitting at a table, shaking and pale (Warner, 2005). Pogany returned to his room, but became nauseous and vomited a half hour later. He was panicked and trembling, and when finally able to sleep, had nightmares of the room exploding, waking to find that the nightmare continued as a hallucination. Still shaking the next morning, Pogany sought out the team

military, and the Army in particular – since it is the largest branch of service and has deployed the greatest number of service members – found itself under increasing pressure to mount a visible response to the perceived threat of PTSD among combat-deployed personnel.[4]

Then, on February 18, 2007, *The Washington Post* headlined the first in a series of articles exposing "neglect" and "frustration" among wounded OEF/OIF soldiers receiving care at the nation's most prominent Army hospital, Walter Reed Army Medical Center.[5] The initial article in the series described the decrepit condition of outpatient housing, complete with pictures of injured soldiers standing in front of walls crumbling and black with mold, and characterized the institution's outpatient facilities as having become nothing more than "a holding ground for physically and psychologically damaged outpatients." Dana Priest and Anne Hull, the story's authors, also wrote that, in contrast to the inpatient hospital's spotless

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sergeant and was told to "get himself together," "act like a soldier," and to "go away and think about what he was saying, because it could lead to serious complications for his career" (Warner, 2005). Pogany's weapons were confiscated. The next day he again approached the sergeant and requested help, after which he was sent to Tikrit and held on suicide watch. After several days, he was visited by a chaplain who told him the nightmares and trembling were normal and took him to the nearby CSC unit. There, an army psychologist also told Pogany his reaction was normal, but recommended to his superiors that Pogany be given short-term care with the CSC unit. Instead, Pogany was called before his superior officers and berated for his behavior, then told he would be immediately shipped home to Colorado (Warner, 2005).

Once home, Pogany was stripped of his job, personal weapon, and security clearance, and charged with cowardly conduct under Article 99 of the Uniform Code of Military Justice, the first such charge since 1968 (Warner, 2005). Pogany continued to experience symptoms of panic, confusion, and depression, but chose to fight the charges rather than accept the military equivalent of a plea bargain. Charges were first diminished to dereliction of duty, then later dropped entirely after Pogany was found to have suffered brain damage following Lariam toxicity resulting from the malaria prophylaxis he was provided prior to deployment (J. McHugh, 2004).

[4] Although beyond the scope of this dissertation, a careful comparison of the similarities and differences in responses made by the Army, Air Force, Navy and Marines, and by active-duty and reserve units, would likely provide important insight into the cultural and structural differences between the service branches in the U.S. Armed Forces.

[5] (Priest & Hull, 2007a)

reputation, “the outpatients in the Other Walter Reed encounter a messy bureaucratic battlefield nearly as chaotic as the real battlefields they faced overseas.” They charged that servicemen and women were being denied both psychological treatment and help in wrangling the labyrinthine bureaucracy of the military disability and healthcare systems.

Fallout from the story was immediate and intense. By March 1, Secretary of Defense Robert Gates had endorsed the Army’s decision to relieve Major General George Weightman from his post as the Commander in charge of Walter Reed, saying in a press release that, “The care and welfare of our wounded men and women in uniform demand the highest standard of excellence and commitment that we can muster as a government. When this standard is not met, I will insist on swift and direct corrective action and, where appropriate, accountability up the chain of command.”[6] The Secretary of the Army, Francis Harvey, resigned the next day. The scandal reverberated across a public landscape in which support for American troops serving abroad remained high. Walter Reed was widely cited, in the popular press and at the level of everyday conversation, as evidence of how the government was failing America’s service members. By the end of March, President George W. Bush had toured Walter Reed, made a formal apology, and established a special panel to investigate medical care for wounded warriors.

But the matter was not yet closed. What began as an outrage centered primarily on the Army’s failure to provide adequate care for solders’ physical injuries spilled over into concern

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[6] (Press Release, 2007)

about their psychological well-being as well.[7] A few months later, in June of 2007, Priest and Hull again made front page news with a continuation of their "Walter Reed and Beyond" series. The tagline of their story trumpeted that, "Troops Are Returning from the Battlefield with Psychological Wounds, But the Mental Health System That Serves Them Makes Healing Difficult."[8] Priest and Hull faulted both the Department of Defense and the VA for failing to make mental health treatment and disability services more accessible to returning service members. Their reporting was met with gratitude by military families and veterans' advocates outraged at gaps in care, particularly for those veterans and service members living in rural areas, and at the dizzying paperwork and long delays associated with filing compensation claims for service-related disabilities. Again the coverage struck a chord, and the head of the VA resigned in disgrace a month later.[9] In acknowledgement of the Walter Reed series' impact, *The Washington Post* received the 2008 Pulitzer Prize for Service Reporting. The awarding officials praised the paper's coverage for "evoking a national outcry and producing reforms by federal officials."[10]

The 2007 Walter Reed scandal brought the aftereffects of war for service members to the forefront of public attention, and clarified two things about the U.S. military and the challenges it was facing after five and a half years of the "Global War on Terror". First of all, the military was feeling overstretched by the demands of conducting a ground war on two fronts. Service members were under growing strain, plagued by long and repeated deployments, stop-

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[7] Given the stigma around psychological issues in the military, it seems reasonable to question whether the fallout would have been as severe if the problems had not been identified first among physically, visibly wounded service members before being linked to those who were psychological wounded as well.
[8] (Priest & Hull, 2007b)
[9] (Press, 2007)
[10] (Pulitzer, 2008)

loss measures that prohibited soldiers from leaving the military when their contracts were up,[11] and the increasing frequency with which previously non-deploying service members were being asked to deploy as support staff for combat troops.[12]

The Walter Reed scandal also made it clear that the American public was not willing to accept substandard care for service members. The very idea ignited public opinion against military leadership. In the wave of firings and resignations that followed, the scandal also demonstrated that the military as an institution was responsive to public pressure, and could be made to act quickly and dramatically if subject to the appropriate leverage.

Nonetheless, although it was the Walter Reed scandal that made military (and VA) responses to physical and mental health problems into front-page news, the military had been on the defensive against charges of negligent mental health services since at least 2003. In July of that year, only a few months after the initial invasion into Baghdad, five soldiers then serving in Iraq committed suicide in the space of a few weeks. The Army responded by creating a

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[11] Stop-loss – a policy placing involuntary extensions on service members' terms of service - was implemented in 2004 amidst the realization that the Army was understaffed to maintain a ground war on two fronts (Iraq and Afghanistan). Under this policy, active duty and reserve soldiers whose contracts had expired and who had planned to leave the Army were forced to serve a full additional deployment of up to 15 months. Officials claimed that the measure protected units from attrition occurring right before combat deployment, thus helping units to retain seasoned members at the time they were needed most, putting "the best fighting force on the battlefield" (Squitieri, 2004). However the policy's implementation was widely criticized, with detractors calling the policy a "back-door draft" (""Stop Loss" Continues," 2004; White, 2004).

[12] At the same time, the military's health care resources were being taxed as they had not been since Vietnam. New medical technologies enabled physicians to save a much higher percentage of wounded service members. Mortality rates among those injured have dropped from 30% in World War II and 24% in Vietnam to around 10% in the current wars (Gawande, 2004). This unprecedented survival rate has left the military struggling with the necessity of caring for very seriously injured service members.

Mental Health Advisory Team (MHAT), charging the team to go to Iraq and investigate the suicides.[13]

The team's report, known as MHAT–I, revealed that service members experiencing combat stress were faced with both social and structural barriers to care. The report noted how few mental health clinicians were available to provide treatment services in-theater. Service members described feeling uncertain about where to go for help and being unable to get time off from work in order to seek medical care. But the most striking obstacles were related to stigma: 59% of soldiers worried that seeking mental health care would result in their being seen as weak; 49% expressed concern that their unit would be less confident in them; and 46% feared their leaders would blame them for having a problem.[14] For their part, mental health providers expressed frustration at the lack of anti-depressants and other pharmaceutical medications available for prescription, and the inconsistent care accessible to units posted in remote parts of Iraq.[15]

What the MHAT report did not discuss was the change in military life wrought by the 1973 move away from the draft and towards an All-Volunteer Force.[16] One career Army officer I

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[13](MHAT, 2003) The team released their report in March of 2004, in what would become the first in a series of annual MHAT reports documenting elevated rates of psychological symptoms among service members serving in Iraq and Afghanistan. The initial MHAT report found that 23% of soldiers surveyed in Iraq reported moderate or severe stress, emotional, or family problems, with 17% of the sample screening positive for depression, anxiety, or traumatic stress. Of those who screened positive, only 27% reported having received attention from a health professional or chaplain; even among those expressing a desire for help, only 32% had received any. It is difficult to compare these numbers to prior wars, as combat zone mental health surveillance has improved considerably over the past few decades.

[14] Another study conducted at roughly the same time found that, among soldiers returning from Iraq who screened positive for a possible mental disorder, 65% feared being seen as weak, and 59% worried their units would have less confidence in them (Hoge, et al., 2004).

[15] (MHAT, 2003)

[16] This change was the result of increasing controversy over the draft during the Vietnam era. Lutz (2001) has written that, "As the war ended, the military had to change in the face of massive refusals to soldier,

interviewed pointed out that there is now far greater impetus to take care of soldiers now than there has been in the past. Because pre-1973 service members were subject to a draft, he suggested, there was less need to provide persuasive evidence that the Army was an institution that took care of its own. Or, as he put it, the Vietnam-era Army could 'use 'em up and spit 'em out' without fear of draining the available pool of potential recruits. After 1973, the military fell subject to a constant need for new people, with the corresponding need to hold onto service members, as it is cheaper and more efficient over the long run to maintain good personnel than to replace them. The contemporary military finds itself needing to keep its publicity positive, lest general attitudes interfere with its ability to continually bring in new recruits.[17]

Meanwhile, the mid-2000s saw concerns about the ability of the U.S. Armed Forces to keep up with the logistical requirements of a ground war on two fronts given ever-present voice in the media,[18] and evidence of service members' poor mental health seemed to only increase the sense of urgency. Faced with such challenges, clinicians and some leadership within the military were forced to recognize that PTSD and other combat-related mental health problems had the potential to seriously undermine a force already stretched too thin. There was much talk of keeping up "force readiness" or "mission readiness," that level of preparation that allows a military unit to do what it needs to do at any given moment.

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and the potential recruit's now pressing suspicion that an army job entailed more than career training." (167)

[17] The recession of 2008-2009 seemed to lessen the problem of recruitment for at least some branches of the U.S. Armed Forces. Army National Guard recruitment was up sufficiently in 2009 to allow the Guard to begin trimming signing bonuses and educational benefits that had skyrocketed in 2005, in an attempt to meet a 20,000 soldier shortfall (Vanden Brook, 2009).

[18] (O'Hara, 2006; White, 2004); One article in the British *Observer* told of how, "Exhaustion and combat stress are besieging U.S. troops in Iraq…" and claimed that, "As desertions and absences increase, the military is struggling to cope with the crisis"(Beaumont, 2007).

Thus, responding to both external public pressure and a recognition of the need to maintain force readiness, top leadership within the Department of Defense and each of the Armed Forces set in motion a series of efforts aimed at providing improved combat stress prevention and treatment resources for service members.

In the next few sections, I turn my attention to these efforts. Whereas in the last chapter, I considered how families derive their responses to the problems created by PTSD, in this chapter I will focus on how military leadership have attempted to accomplish roughly the same task, attempting to support troop strength through positive mental health. Included among these approaches was the creation of several new programs. However, much was also done to step up the reach of previously existing care networks, many of which have been in place since as far back as World War I. In fact, the American military, and those clinicians and leaders working within it, have been forging responses to combat stress for nearly a hundred years. It is worth taking a few moments to explore this history in order to better understand how these responses came into being, and – in preparation for Chapter Six's discussion of PTSD within VA mental health care – to observe how they have evolved over time in line with changing ideas about combat stress within an increasingly professionalized mental health field.[19]

A Brief History of Combat Stress

Although PTSD as a diagnosis was first formalized by the American Psychiatric Association in 1980 (a story I will also turn to in Chapter Six), the American military community has recognized the aftereffects of combat since at least the Civil War. These aftereffects have

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[19] It is widely argued that modern biomedical psychiatry was profoundly shaped by its periods of wartime intimacy with the military, occurring at regular intervals throughout the 20th century (Pols & Oak, 2007).

gone by different names and merited different responses over the course of time. Military physicians during the Civil War recognized and classified psychiatric casualties into three main categories: insanity, nostalgia, or what was called "soldier's heart" or "irritable heart".[20]

Individuals who were found to be insane were prevented from engaging in military service, and could be sent to the Government Hospital for the Insane in Washington, D.C. or dealt with as individual commanders saw fit, which often included being treated as malingerers or shirkers.[21] The second category in common usage was that of "nostalgia," a derivative of a French diagnosis describing the mental suffering of soldiers away from home, which referred to symptoms of depression, confusion, loss of appetite, and gastrointestinal trouble.[22] The third category, "soldier's heart," dealt with the impact of overexertion and stress upon the heart, and was said to result in palpitations, nervousness, and sleeplessness--a *physical* problem rather than a psychological one.

Following the end of the Civil War, two issues arose that were to become familiar in the coming century: 1) the social and psychological problems of veterans in the years and decades after the war, and 2) the question of government compensation and treatment for those

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[20] (Dean, 1997)

[21] Eric Dean (1997) has written: "As an indication of how extreme this attitude could be, when men presented themselves with hysterical paralysis of an arm or leg, they were anesthetized to see if they really were suffering from paralyzed limbs as they claimed; if the limb was found to have no organic or objective deficit, the man was considered to be a malingerer and returned to duty….Union rank-and-file doctors thus generally seemed to consider it their duty to return 'shirkers' to the front lines, and the letters, diaries, and memoirs of these medical men generally reflect almost a zeal to implement the official policy of detecting cases of feigned insanity in soldiers seeking to escape combat or to secure a discharge from the service.""

[22] Dean (1997) also argues that "sunstroke" – common enough among soldiers marching 10 to 20 miles a day carrying heavy loads –came into use as a way of describing men who became insane or terrified during battle.

problems deemed "war-related".[23] Historian Eric Dean has uncovered accounts of physically sound veterans who became insane, unable to work, violent against family and friends, suicidal, or addicted to alcohol. In other words, Civil War veterans appear to have struggled with many of the functional and behavioral problems we continue to see among PTSD-diagnosed veterans today.[24] Certain individuals, moreover, were able to secure government pensions for war-related psychological disability, although such claims were denied more often than not.[25]

By World War I, much greater notice was taken of the phenomenon of combat trauma. Curtis E. Lakeman, the Assistant to the Director General of the American Red Cross, wrote in 1918:

> It is a fact of sinister significance, not widely appreciated, that the insanity rate of men in the army increases nearly 300 per cent in time of war. Facilities for the treatment of war neuroses are being developed at the Army hospital at Plattsburg, New York. It has come to be recognized that nervous breakdown in the service does not differ essentially from the same conditions observed in civil life except that the ordeals of battle and the trying sights and sounds which the soldier experiences are the aggravating cause.[26]

It is worth noting that, by the time of Lakeman's writing, psychiatry had vastly matured as a professionalized medical discipline. One can see something of this in the above quote, with its authoritative tone, its attempt to take a quantitative measurement of the "insanity rate," and its confident description of the cause (the experience of battle) and course (not essentially different from similar conditions in civil life) of "war neuroses."

In fact, very early in WWI, at the end of 1914, British physicians in France had begun seeing patients who were unable to see, smell, taste, or remember; who vomited excessively; or

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[23] (Dean, 1997)
[24] At the very least, such cases reveal that these problems, when occurring among post-combat veterans, were given a similar sort of causal attribution as they are today. They were seen as a consequence of war.
[25] (Dean, 1997)
[26] (Lakeman, 1918: 126)

who were possessed by continual tremors, but displayed no injury or organic illness.[27] The psychologist Charles S. Myers published a 1915 article attributing these symptoms to a sudden shock to the nervous system caused by the explosion of artillery shells within close range.[28] Myers called the phenomenon "shell-shock" and, although he later discarded the idea of physiological shock as the cause of the syndrome, the name continued to be used for years to come.

Despite Myers' rapidly developed theory of shell-shock, there was a wider sense that WWI had caught the medical profession by surprise, and without the necessary tools to treat the problems they were seeing. While medicine and surgery had developed some consensus as to the principles guiding their treatment of bodily injuries, psychiatrists found themselves at a loss for how to deal with the casualties they were seeing.[29] There was considerable controversy over what conditions were the result of physiological/neurological causes – as shell-shock was thought to be - and what conditions were the result of psychological causes, like hysteria and the neuroses. The disagreement took shape as part of a larger debate over the centrality of the

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[27] (Shephard, 2001): Hysterical paralysis was a common form of what was considered to be shell-shock at the time, and marks the tail end of the epidemic of hysteria that swept the U.S. and much of Western Europe during the second half of the 19th century. Many of those Victorian ladies famous for swooning on couches were said to have hysteria, and often exhibited a paralysis of some limb or sensory function. One set of symptoms we see in early descriptions of shell-shock are these kinds of paralysis, which virtually disappear from later descriptions. This seems to be one example of how cultural ideas about illness get inside the brain and the body to shape the manifestation of physical or emotional distress.

[28] (Shephard, 2001)

[29] W.H.R. Rivers, a prominent British psychiatrist and anthropologist, wrote in 1920 that, "The medical administration of our own and other armies was wholly unprepared for the vast extent and varied forms in which modern warfare is able to upset the *higher functions of the nervous system* and the *mental activity* of those called upon to take part in it" (1). He bemoaned the fact that, "The outbreak of the war found the medical profession with no such common body of principles and measures as those which enabled Medicine and Surgery to deal so successfully(?) with the more material effects of warfare …."

physical brain as opposed to the psychological mind in determining human behavior and experience (a debate that has continued in one form or another to this day).

Suffice to say that, at the start of WWI, most of the symptoms now associated with PTSD were attributed to shell-shock, and thought to be caused by a disturbance of the physiological nervous system – the body – through exposure to the vibrations of artillery explosions. By the end of that war, however, the war neuroses were largely thought to result from psychological or emotional problems, from traumatic neuroses occurring within the mind. Thus the understanding of what combat trauma actually meant – what processes it revealed within the person – changed dramatically within a few short years.[30]

At the same time that clinicians were arguing over whether the etiology of shell-shock was psychogenic or organic in nature, they were also engaged in negotiating with military unit commanders over how to distinguish between cases representing psychological strain and those of cowardice or malingering in the face of an ongoing, grueling war. Ben Shepherd has written

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[30] From this unresolved legacy arose the British army's habit of lumping together all "war neuroses" in the early part of WWI, drawing on a list which grew to include shell-shock, hysteria, neurasthenia, Disordered Action of the Heart (DAH) (not unlike Soldier's Heart), and Not Yet Diagnosed (Nervous), which was a loose diagnosis that gave military physicians a temporary catch-all category for potential war neurosis cases (Shephard, 2001). By 1916, shell-shock was no longer thought to require an actual concussion of the nervous system by artillery, but was felt to be caused by emotional rather than physical shock. The diagnosis of shell-shock was increasingly being replaced by "war neurosis" or "traumatic neurosis" (Young, 1995). Even Disordered Action of the Heart, the only remaining war neurosis thought to have an organic cause, was critiqued by the end of the war as describing undiagnosed heart problems or a type of neurasthenia (Young, 1995).

Although war neurosis was a more common diagnosis than shell-shock by the end of WWI, this should not be taken as a victory for advocates of the psychological model for combat trauma. In the years following the war, two key figures - W.H.R. Rivers and Abram Kardiner - would produce their own biological explanations for the "psychoneuroses," becoming part of the surge of biological psychiatry that, although subordinate to the psychoanalytic tradition in the coming decades, would resurface during the Vietnam era to provide much of the frame for PTSD as we know it today (Young, 1995).

that the British Army in WWI had a "rough and ready model of human psychology, and its own clear-cut labels. Men were either sick, well, wounded, or mad; anyone neither sick, wounded, nor mad but nonetheless unwilling to or incapable of fighting was necessarily a coward, to be shot if necessary."[31] World War I was, at least for the Europeans, characterized by long battles conducted out of death and disease-ridden trenches, a miserable and exhausting form of warfare that went on for years.[32] At certain points in the fighting, as when the Germans launched a gas offensive in March of 1918, cases of hysterical paralysis and other psychiatric problems outnumbered the wounded, sometimes by as much as 2:1.[33] Cases of those who were so frightened, so exhausted, or so traumatized that they could no longer fight began to outnumber the cases of those physically wounded.[34] The task of maintaining sufficient manpower to fight while effectively treating psychiatric casualties necessitated the creation of an effective system of triage.[35]

The system developed by the British and French, and adopted later with minor modifications by the Americans, was designed in part as an attempt to keep fighting men as close to the front as possible. As an added benefit, it provided the opportunity to sort cases of

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[31] (Shephard, 2001: 25); Shepherd has also written of the consequences of such a limited model, describing the cases of 307 men who were executed by the British Army for cowardice between 1914-1918, many of whom may have been suffering from shell-shock according to case descriptions. This issue remained of public interest in Britain for decades, with the British Ministry of Defense finally issuing a group pardon for the men in August of 2006 (G. Roberts, 2006).

[32] (Shephard, 2001)

[33] (Chermol, 1985; Shephard, 2001)

[34] The notion of "vital exhaustion" retains power as an explanatory model for illness in European behavioral medicine (e.g. Prescott, et al., 2003).

[35] Shephard describes the chaos created by the policies in place prior to the creation of a system for psychiatric triage: "Depending on the circumstances, a shell-shocked soldier might earn a wound stripe and a pension (provided his condition was caused by enemy action), be shot for cowardice, or simply be told to pull himself together by his medical office and sent back to duty." (Shephard, 2001: 29)

mental and physical exhaustion (which were seen as short-term problems) from cases of severe war neurosis.[36] The model behind the system was an outcome of trial and error in the early part of the war, when it was realized that soldiers returned to combat in a timely fashion rather than being sent home seemed to recover quicker and more fully.[37]

Briefly, the system relied upon three echelons with responsibility for preventing stress casualties, as well as providing triage, treatment, and – as promptly as possible – the soldier's return to duty. The first echelon of care involved assigning a psychiatrist to each Army division, with mobile care units available close to the front. Combat stress cases were given psychiatric evaluation and the majority returned to duty after a brief rest.[38] Second echelon care was provided by neurological hospitals behind the lines. These hospitals offered longer periods of rehabilitation to more severe cases; still, some 55% of these were returned to duty within a few weeks.[39] Third echelon care occurred in a rear-located base hospital, where cases received further treatment, and – depending on the treatment's success – could ultimately be returned to the front, reassigned to other duty, or evacuated home.[40] This rough system of triage seemed to do an acceptable job of allowing clinicians to sort through psychiatric casualties and funnel soldiers into care as needed, and was ultimately the system that got the British, French, and Americans through the war.[41]

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[36] (Shephard, 2001)
[37] (Shephard, 2001)
[38] (Shephard, 2001)
[39] (HQDA, 1994)
[40] (HQDA, 1994; Wanke, 1999)
[41] Although war neurosis was a more common diagnosis than shell-shock by the end of WWI, this should not be taken as a victory for advocates of the psychological model for combat trauma. In the years following the war, two key figures - W.H.R. Rivers and Abram Kardiner - would produce their own biological explanations for the "psychoneuroses," becoming part of the surge of biological psychiatry that,

In later years, changes in civilian psychiatry prompted a re-evaluation of the echelon system's reliance on treatment rather than prevention. Adolph Meyer was the dominant voice in psychiatry between the wars, and his school of thought emphasized the characteristics of the individual, including the role of past life experiences in shaping a person's response to stressful situations (such as combat).[42] WWI had revealed that not all individuals respond with equal resilience or neurosis to wartime experiences, and this was taken as evidence that it was the predisposition of the individual that resulted in neuropsychiatric disorder rather than the innate challenges of battle itself.[43]

This perspective became the cornerstone of a radical new plan to prevent combat neurosis by screening out unsuitable individuals prior to their recruitment into the armed forces.[44] The new screening process, though vigorously implemented, was largely a failure. Some 1.3 million American service members – all of whom had passed without trouble through the screening process – experienced a psychiatric illness during the course of WWII, and in July of 1943, the three-echelon prevention and treatment system developed during WWI was re-implemented.[45] The old echelon system was updated with new technologies, adding group therapy and sedatives like Valium to the treatment repertoire of military clinicians.

The first half of World War II brought important lessons about combat trauma. First of all, psychiatrists came to realize that any individual, under the right circumstances, was vulnerable to combat stress, because intensive screening had done little to reduce the

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although subordinate to the psychoanalytic tradition in the coming decades, would resurface during the Vietnam era to provide much of the frame for PTSD as we know it today (Young, 1995).

[42] (Shephard, 2001)

[43] (Wanke, 1999)

[44] (Pols & Oak, 2007; Wanke, 1999)

[45] (Wanke, 1999)

psychiatric casualty rate. Second, they came to appreciate that the greatest source of strength for soldiers was cohesion within the combat unit. Service members who were kept close to their units were more likely to recover and return to duty. And last but not least, psychiatrists observed that treating individuals with combat stress was more effective when it included communicating the expectation of a full recovery. It was this last realization that led to another change in the way combat stress was named and understood: the term "war neurosis" began to be replaced with the less-stigmatizing "combat fatigue".[46] Having incorporated these observations, the triage system largely held up – with a few revisions – through the Korean, Vietnam, and First Gulf Wars.

The U.S. Army's contemporary system of Combat and Operations Stress Control (COSC) is based around the same three-tiered program developed by the British in World War I. A typology of combat stress distinguishes combat stress from critical incident stress (a stress reaction to a specific incident), battle fatigue, and others - all of which diverge from PTSD because they focus on the stresses of recent or ongoing events, whereas PTSD can, by definition, only be considered when 30 days have elapsed since the trauma.[47] It is significant, too, that while PTSD is generally accepted within professional mental health to be a *mental illness*, combat stress is identified in many military materials as representing a *normal reaction to challenging events*.[48] It is officially defined as, "The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of service members who have been exposed

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[46] (Wanke, 1999)
[47] (HQDA, 1994)
[48] (CSOC, 2003; Hamre, 1999)

to stressful events in war or military operations other than war."[49] The military has retained its emphasis on normalizing the experience of combat stress.

Though it has evolved somewhat, the basic COSC system is still intended to provide a multi-pronged strategy for the prevention and treatment of combat stress reactions (which, in the military's acronymic language, are referred to as CSRs). This strategy ideally includes a variety of activities, including pre-deployment and post-deployment mental health screenings, a system of mental health surveillance, and multilevel management of CSRs (by the service member, buddies, and leaders as well as by clinical consultants).[50] Composed of army psychiatrists, clinical psychologists and other mental health professionals, Combat Stress Control Units (CSC units) are deployed as mobile units throughout the combat zone, with the intention of providing combat stress support to soldiers and leadership wherever is necessary, available on demand.[51] The ongoing development of second-generation anti-depressants and other psychotropic medications with relatively few side effects has revolutionized the pharmaceutical arsenal of clinicians providing care in the field.[52]

Otherwise, the official protocol for managing stress casualties during the current conflict has remained surprisingly consistent with that of previous wars. Individuals displaying symptoms are supposed to be examined by CSC units or other available mental health personnel

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[49] (MHAT, 2003: E-6)
[50] (Hamre, 1999; HQDA, 1994; MHAT, 2003)
[51] (Hamre, 1999; HQDA, 1994)
[52] The increasing use of pharmaceuticals by military personnel on combat deployments has been the subject of some media controversy (M. Thompson, 2008), although the data on this issue remains scattered. I have been unable to locate reliable statistics on how many military personnel serving in Iraq or Afghanistan are currently taking psychoactive medications. The use of such medications during combat raises important questions as to the potential impact on service members' experiences of trauma and the processing of emotion and memory in the aftermath of traumatic events, but investigations in this area remain fledgling.

and provided with 24-72 hour "restoration" treatment (usually in Iraq or Afghanistan). "Slow-to-improve" cases may be held for 4-28 days and given additional treatment (usually in Iraq or Kuwait). The most severe cases may be evaluated for additional treatment and/or evacuation to Europe or the U.S.[53,54]

In fact, glancing back over the historical treatments for combat stress, it is the lessons that have survived over time that are perhaps the most striking: keep soldiers as well-cared for as possible during their daily engagements; keep stress casualties near the unit and return them to their unit as soon as possible; provide casualties an opportunity to catch up on food, sleep, hydration, and hygiene; and where appropriate, offer simple reassurance, thoughtful listening, the opportunity to talk over events as they happen, and the expectation of full recovery. The guiding philosophy here is in line with the Army's stated position that combat stress is a normal reaction to severe conditions and can largely be prevented or treated with basic care. The goal is always the same: get soldiers back on duty as quickly and as safely as possible.

Top-Down Responses (Pressure Works)

This, then, was the combat stress response system in the early years of the Iraq war, as accumulating studies revealed that combat in Iraq was resulting in symptoms of PTSD among

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[53] (HQDA, 1994; MHAT, 2003)

[54] Four of the clinicians interviewed had each spent a year providing mental health care in Iraq. One of them expressed consternation that very little research has been done examining the most effective therapeutic treatments for combat stress during deployment. His impression was that the status quo was based on anecdotal evidence rather than formal research, and that changes were generally decreed from the top-down by interested leadership rather than based on the accumulation of clinical evidence. This critique comes in interesting contrast to recent efforts at the VA described in the next chapter, which have relied on the use of an evidence-based model to re-structure care for PTSD.

11-19% of U.S. troops.[55] Understanding the history and complexity of the Army's COSC system makes it clear that the U.S. military has, in fact, long acknowledged the potential impact of combat stress on service members. Indeed, the *Leader's Manual for Combat Stress Control* includes a list of dire warnings about how mission goals can be compromised if soldiers begin functioning at less than full capacity ("vigilance deteriorates," "decisions become slow and inaccurate," etc.).[56]

And yet, reacting to mounting public pressure in the mid-2000s, military leadership began harnessing the massive resources of the Armed Forces to incorporate *additional* efforts for preventing and treating both acute and post-deployment stress reactions. Although there was some variation by branch of service, these efforts can be roughly grouped into three broad categories.[57]

The first of these focused on improving access to professional mental health services overseas and on military posts across the U.S. Special attention was paid to increasing the number of clinicians available to offer services and to streamlining the process by which struggling service members were referred to appropriate services. Faced with a growing shortage of mental health care providers as military clinicians migrated back into civilian life in an attempt to avoid long deployments, the Army announced in the spring of 2007 that it was hiring an additional 200 mental health care providers to help close the gap, a number that had increased to 330 by the following year.[58] In response to critiques that the mental health care on

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[55] (Hoge, et al., 2004)
[56] (HQDA, 1994: 8-9)
[57] The U.S. military represents such a massive and complex institution (or set of institutions, depending on one's perspective) that I am not able to offer a comprehensive overview of these efforts.
[58] (Richie, 2008)

offer was of poor quality, the Center for Deployment Psychology (CDP) was formed and funded by Congress. The CDP's mission was to train mental health care providers "to provide high quality deployment-related behavioral health services to military personnel and their families."[59] In addition, Air Force psychologists were called upon to deploy with greater frequency in support of Army units, learning to run Combat Operational Stress Control Teams in accordance with Army protocol.

A mandatory post-deployment screening process – which consisted of service members completing what was called the Post-Deployment Health Assessment (PHDA) within 30 days of returning home from overseas – had been in place for some time. The PDHA was intended to provide surveillance data on the health and well-being of every deployed service member, as well as to ensure that those experiencing physical or psychological symptoms were referred for further evaluation. It contained questions about PTSD symptoms, medications taken during deployment, and combat exposure while in-theater.

Although the PDHA was a well-considered effort to keep an eye on service members returning home, it quickly became clear that it was inadequate to the task. Among the military clinicians I spoke with in the course of the study, it was generally accepted that the PDHA was problematic because so many soldiers were hesitant to report symptoms. Word went around among service members that, if you reported negative symptoms, you would be held back from returning home for a week or two while you underwent evaluation by the Mental Health people. In one deployment health workshop I attended, the presenting clinician admitted flat out that, 'I lied on mine' because 'if you mark anything you can't go on leave!'

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[59] (CDP, 2009)

To their credit, the DoD eventually realized the PHDA was not working as intended and an additional measure was introduced in 2005. This was the Post-Deployment Health Reassessment (PDHRA), a form that was to be completed 90-180 days after the return home. The PDHRA requested further information on psychosocial issues and family problems that might have become evident in the early months post-deployment, and based on what I heard from clinicians and at conference presentations I attended during 2007 and 2008, was generally thought to be catching more individuals in need of professional evaluation.[60]

The second category of changes pushed by military leadership fell under the broad rubric of working to decrease stigma and improve awareness of readjustment-related stress and symptoms to watch out for. One recent initiative developed by the Walter Reed Army Institute for Research attempts to educate soldiers about the challenges of transitioning to and from the combat zone using a program called "Battlemind." The goal of Battlemind, which is often taught by chaplains in a workshop format, is to help soldiers know what to expect as they depart for a combat tour, and as they embark upon the return home to family life. The program is organized around the idea that service members develop certain skills – i.e. the battle mindset – in order to function successfully in the combat environment; these skills include developing close relationships with buddies, practicing targeted aggression, focusing on accountability and responsibility, and taking control of any given situation. These attitudes and behaviors may save lives in the combat zone, but may also create problems if retained outside the deployment setting. As one Army brochure puts it, "Battlemind can be hazardous to your social and

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[60] (C. S. Milliken, J. Auchterlonie, L., & C. W. Hoge, 2007a)

behavioral health in the home-zone."[61] Early evaluation of the program has found that soldiers who receive Battlemind training prior to deployment report fewer mental health problems following the return home.[62,63]

This attempt to normalize post-deployment challenges represents only one means by which military leadership have tried to decrease the stigma around combat and readjustment stress among troops. Along the same lines, military mental health services now go by the name of "Behavioral Health", a change intended to summon up fewer frightening connotations of shrinks and straight-jackets. Concerns about confidentiality within the tight-knit Armed Forces has led to the creation of anonymous support and referral services available via telephone and the internet, as part of the Military One Source program.[64] In a practical effort to reassure service members who might be afraid of losing their security clearance – a common outcome of seeking mental health care in the past and one that may have implications for long-term

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[61] Brochure: "Battlemind Training I: Transitioning from Combat Home," developed by the Walter Reed Army Institute of Research Land Combat Study Team.

[62] (MHAT, 2008)

[63] In thus educating soldiers about this post-deployment transition or readjustment period, the Army is explicitly working to normalize combat behaviors and reactions that clinicians often call by another name: symptoms. Among the phenomena that Battlemind materials describe are hypervigilance, emotional withdrawal, and inappropriate anger and aggression, all of which clinicians might well describe as symptoms of PTSD. Chaplains and Army clinicians give several reasons for this different way of framing things, focusing in particular on trying to minimize the anxiety that service members may feel upon returning home to find readjustment more difficult than they might have expected. Chaplain and military clinicians express hope that these experiences will be less alarming if anticipated and understood within a framework of what is "normal." In addition, by using the Battlemind workshops as an opportunity to talk about danger signs, these providers also work to educate soldiers about when it is time to seek out added help, usually in the form of professional mental health care.

[64] (Richie, 2008)

employment prospects – regulations were changed to exempt service members from losing security clearance over a problem related to their military experience.[65]

The third category of major changes lay in the growing emphasis on providing information and services to service members' families. In Chapter Three, Laurie described attending workshops for spouses when Josh was on the way home after his second deployment as a Marine. During 2007-2008, the chaplains I spoke with were offering marital counseling and workshops to reunited families. I attended several local seminars aimed at educating civilian mental health providers about the needs of military families.[66] Even the Army's Battlemind program has developed a specific unit for spouses, which provides much of the same information as for service members, but with a focus on how spouses can help in easing the transition home.[67]

One can argue whether any of these changes, or the combat stress control system already in place, represent *enough* of an attempt by the American military to protect and provide for service members. What is clear, however, is that the military as an institution is –

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[65] (Richie, 2008)

[66] It was usually noted during these workshops that the attention paid to military families represented a significant change from older Army attitudes. The new emphasis on family life in the military, providers joked, signaled that the days of, 'If we wanted you to have a wife we would have issued you one!' were now past.

[67] The Battlemind program for Spouses focuses on identifying a series of behaviors – taking control of household and family affairs, avoiding discussion of deployment, and so forth - and reframes them in context of the environment soldiers lived in during deployment. For example, one Battlemind brochure describes how soldiers in combat "Controlled their emotions in order to be successful in missions." The brochure goes on to list how this tendency toward emotional control may create conflict if carried over into the home environment, noting that "Spouse or Soldier expectations for emotional or physical intimacy might not be met upon return." Suggestions are then given for helping to work through this aspect of the post-deployment transition. Spouses are urged to "Be patient," while soldiers are cautioned to "Appreciate the difference between sex and intimacy."
https://www.battlemind.army.mil/assets/files/spouse_battlemind_training_post_deployment_brochure.pdf

much like a veteran's family may be – responsive to perceived crisis, acting out of concern that disaster may result if service members' post-combat and post-deployment struggles are left without appropriate attention. The nature of the crises faced by families and faced by the military are different. The family may be concerned that a service member will become more troubled over time (with potentially tragic results, as cautionary tales of veterans' suicide, substance abuse, and homelessness continue to circulate), or that he will be unable to live up to his expected role as participant and provider. Within the military, concern may arise out of worry over service members' well-being, or from the recognition that service members struggling with mental health problems are less able to contribute to force readiness. Regardless, it seems clear that both veterans' families and the U.S. military face pressures to work towards the best possible well-being for current and former service members.

And yet, we already know that it does not always work out this way. Family members sometimes lash out at veterans rather than supporting them. Military leadership sometimes directly contribute to mental (and physical) health problems for their troops, continually sending men and women into conflict on the ground in Iraq and Afghanistan and ignoring signs of combat stress among service members like Chris. There is top-down pressure to improve access to mental health care and to decrease stigma, yes, but there are also other pressures, coming from other directions. It is the conflict created by these opposing forces that helps to explain why problems around stigma and care-seeking remain – in Chris' experience, in the MHAT data, and in the lives of the men and women in this study – despite considerable efforts to the contrary, efforts forged from nearly a century of working with combat stress.

What, then, are these other pressures?

The Bonds Between Men (Social Pressure)

One of the pressures that works to perpetuate stigma around combat stress is the socialization that service members are given upon their entry into the military. There has been relatively little exploration of state militaries within anthropology, an absence that results from a long history of mutual suspicion between anthropologists and members of the armed services, whose priorities have occasionally been in conflict.[68,69] Nonetheless, anthropological research among active-duty military personnel in the U.S.,[70] Bolivia,[71] Israel,[72] and Australia,[73] to name but a few, has found that state militaries make use of a variety of socialization practices to foster a sense of shared culture among soldiers.[74] This socialization usually takes place during some form of "basic training" and is intended to serve several purposes. First, it supports the group cohesion and male bonding that is considered essential for fostering trust and efficiency in combat settings.[75] Second, it supports the internalization of a disciplinary hierarchy in which orders will be followed without question, even under conditions of crisis and threat.[76] Third, socialization instills service members with the values of a total institution – Sociologist Erving Goffman's phrase for an institution in which individuals live, work, and play, thus conducting

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[68] Although certainly this has not always been the case, as seen in WWII-era works by Benedict, Mead, and Bateson, among others.
[69] (A. Simons, 1999)
[70] (F. Barrett, 1996; Burke, 2004; Frese & Harrell, 2003; Hawkins, 2001; Katz, 1990; A. Simons, 1997, 1999)
[71] (Gill, 1997)
[72] (Bar & Ben-Ari, 2005; Ben-Ari, 1989, 1998; Kanaaneh, 2005; Kaplan & Ben-Ari, 2000; Lomsky-Feder & Ben-Ari, 1999)
[73] (Agostino, 1998)
[74] (Connell, 2005[1995])
[75] (A. Simons, 1997; Tiger, 1999); One wonders what will happen to our understanding of the importance of "male bonding" in combat as more and more women are recognized for their role in modern warfare.
[76] (Katz, 1990)

their entire lives within its bureaucratic confines[77] – and is thus intended to overcome previous socialization, particularly that which might impede the use of lethal violence.[78] Anthropologists have observed a self-conscious embrace of particular forms of aggressive masculinity within these shared military cultures,[79] and have suggested that, for some individuals and groups, joining the military may serve as a male rite of passage, a culturally authorized way of "becoming a man".[80]

For the men in this study, military socialization seemed to translate into the process by which attitudes about masculinity and personhood that came with them into the military – the attitudes they had acquired throughout childhood and adolescence – were compounded with an additional set of standards for comportment and behavior. This is not to say that the personal and cultural baggage they brought with them were *replaced* (who can wholly set aside the lessons of their early years?), but only that another layer of expectations was added to the mix. For example, one soldier's mother bragged about her son's wonderful way with his kids during his pre-military years as a stay-at-home father. He enlisted in the Army planning to become a medic and 'wanting to save lives,' but after basic training his mother overheard him characterize himself as a 'lean mean killing machine,' something she had never heard from him before. He did not suddenly stop being a wonderful husband and father, but he did acquire a whole new way of talking about himself.[81]

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[77] (Goffman, 1961)
[78] (Bourke, 1999; Burke, 2004; Grossman, 1995)
[79] (e.g. Agostino, 1998; F. Barrett, 1996; Bibeau, 1997; Burke, 2004; Karner, 1998; Katz, 1990)
[80] (Kanaaneh, 2005; Kaplan & Ben-Ari, 2000; Kohn, 2004; Mrozek, 1987{Gilmore, 1990 #1328)
[81] While male gender and masculinity provide one perspective on examining soldiers' experiences in deployment and readjustment, there is no one single masculinity or warrior ethos, even within the relative culturally homogeneity of the U.S. Armed Forces (Mrozek, 1987). Barrett (1996), for example, has deconstructed the idea of a monolithic masculinity within the contemporary Navy, demonstrating that the

In truth, these are the kind of no-holds-barred messages we are used to hearing about in books and movies, in stories that focus on how men may push themselves and in doing so accomplish great feats and heroic victories. But it is essential to remember, too, how important are the bonds between these men, seen in the lasting resonance of phrases like "comrades in arms" and "band of brothers." One of the findings that emerged from the PDS study is that to understand the power of military socialization, it is not enough to focus on boot camp and its messages about strength, toughness, group cohesion, and masculinity.[82] On the contrary, it is necessary to understand military socialization as an ongoing process, continually recreated in the often highly valued relationships between service members and those closest to them in the rank hierarchy: their immediate peers, subordinates, and leadership.[83] Military socialization is a set of values and experiences shared between service members, itself an important part of the relationships these individuals have with one another. Military socialization, therefore, continues as the relationships themselves continue, re-emerging in the interactions between one service member and others that he or she may love, respect, work with, emulate, and train.

Since 31 of the 50 OEF/OIF veterans in the study were officers or NCOs, the men in this group spoke as often about communicating the military's expectations as they did about

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most highly valued elements of a "manly" performance vary considerably by operational specialty. Whereas aviators value aggressiveness, courage, and autonomy, surface warfare officers emphasize the authoritative command of combat operations, technical expertise, discipline, and coolness under pressure. In contrast, supply officers accentuate their control over the movement of information and goods, and, lacking the opportunity to demonstrate their prowess under fire, may invest additional energy in seeking higher rank, thus proving themselves through upward mobility. Barrett's findings do not refute the idea of a hegemonic masculinity within the Navy – he notes that aviators most closely approach the ideal of emotional discipline, audacity, and technical mastery – but rather elucidate how men construct and perform alternative models of gendered excellence *in relation* to such hegemony.

[82] (Although there has been some wonderful scholarship in this area, such as Faris, 1976; Katz, 1990; A. Simons, 1997, 1998).

[83] For more on the important role played by other service members in veterans' lives, please see Chapter Nine.

receiving them. Carlos described teaching his men to be impervious to pain. "I've been hurt so many times that it's like, 'It's just a couple of ribs, you'll get over it.' I've told that to so many people. 'Just ignore it.' Sprains, whatever. 'It'll go away.'" Chris said roughly the same thing, only adding that he was much harder on his men after returning from Afghanistan. "Whenever I'd see someone limping, I'd be like, 'Pick your ass up and move. You better be bleeding or your bone better be sticking out before you quit on me." Physical evidence was necessary – blood or visible bone. Pain was insufficient. "'Oh, my leg hurts!' 'No it doesn't – it doesn't hurt *enough*!'" But Chris wasn't just passing on lessons he had learned in his time with the Army unit. While in Afghanistan, he had watched the soldier he admired most die from wounds sustained in combat. "I knew what the consequences were if you're unprepared." This knowledge only made him push his subordinates that much harder. In enforcing military standards of toughness, he was trying to ensure his men would survive.

Among study veterans, some of life's most powerful messages had been absorbed from peers or supervisors they admired and wanted to live up to. One former Army sergeant, Jose, described a friend killed in combat as, "just like the perfect soldier you would assume you'd copy. He knew his job, he knew other ways to get the job done. He couldn't be pushed around. It didn't matter what rank you are, he never got pushed around. He was in his thirties and he ran faster than just about anyone, did more push-ups, never showed that he was sore." He was physically and emotionally tough, unbending, and his influence far outlasted his days on Earth. Several years after his friend's death, Jose said that he still judges his own worth in reference to this "perfect soldier," and tries to live up to his example.

And of course, the very idea of military socialization seems to suggest something that happens within the military. While this is true, many of these men were also the sons or

nephews or grandchildren of veterans, men who had grown up around military men and been instilled with military values from early childhood. Brian took his son out to play paintball, endlessly watched the Military Channel with him, and joked over the barbeque with his Army buddies while the boy looked on. His son went on to join the Army, just as his father had. How much of a military ethos had Brian communicated long before his son's first day of boot camp?

Even within the context of these relationships, one can see how the shared military emphasis on toughness, discipline and mission focus may begin to play out when troops encounter physical and mental health problems. I heard over and over from veterans about the times that they had urged their buddies to seek mental health care while rejecting the idea themselves. Adam, for example, described talking with one of his former Marines after they had both separated from service. The man told him, "'Look, I'm in a bad way. I mean it's bad, it's real bad.'" Adam told him, "'Look, go to the VA. You're a veteran, go to the VA and get help.'" But, he says, 'Even though …I told him to do that, I still couldn't do it myself, couldn't bring myself to do it. I think it was still that macho attitude."

Later on, talking with Adam about the best way to help veterans struggling with PTSD, he said that the best thing to do was to have another veteran or another member of their unit talk to them. The only catch was finding someone "who can, you know, say something other than 'Hey man, quit being a woman and suck it up. Quit being a sissy and move on about your business.'"

Boots on the Ground (Structural Pressure)

One Army officer I spoke with, Jordan, remains on active duty despite struggling with PTSD, depression, and a neurological disorder he links to the anthrax vaccine he received early

in the Iraq War. He says that he goes through the day feeling like he is 'high' all the time, distant from his body, from his emotions, from the events going on around him. His despair was palpable when we spoke, although he told me – with a vague fierce fire – that receiving a formal PTSD diagnosis and putting together the plan for treatment had given him a lot of hope.

Nonetheless, Jordan was very careful in choosing who among his colleagues to tell about his problems. He likened his unit to a 'bunch of wolves' who could 'smell any weakness.' He related this to what he called the 'boots on the ground' attitude – the idea that nothing matters except how many service members can be called upon to support the mission at a given time. He said that he had already dealt with the fallout from this attitude at a previous post. When he first developed neurological symptoms, his former chief told him right in front of his wife that he didn't want Jordan posted to him if he wasn't in full working order, because he wouldn't be of any use. Jordan was flabbergasted. His wife was furious. Even so, Jordan acknowledged that he understood where the chief was coming from; it was wholly in line with a boots on the ground perspective. Amid a constant effort to accomplish seemingly impossible military goals with too few people and too little time, Jordan felt like this attitude was sometimes necessary. At the same time, he was incensed by the Army's extension of deployments from 12 to 15 months, seeing the increase as undercutting long-term troop well-being to serve short-term goals. He was upset with himself for not speaking out more vehemently against the policy.

In this way, Jordan found himself caught between the de-stigmatizing efforts of official military policy on PTSD, which made evaluation and treatment more accessible to him, and the culture of military life, which places the importance of completing the larger mission above the well-being of any one individual. This was, among the veterans and active duty personnel I

spoke with, not an unusual position to be in. A straight-shooting Army chaplain told me that he saw soldiers getting dual messages. He said that they hear 'We can help!' from mental health providers, while at the same time being told, 'If you're broke, we'll kick you to the curb,' from the rest of the military community.

Eric, a Marine who served in Iraq in 2006, was diagnosed with PTSD while still overseas, shortly after his best friend was killed. He said it was his leadership who noticed he was falling apart, crying intermittently and having a hard time putting sentences together when he spoke. But, he says, "we were so short on people that I didn't want them to pull me out. So I just sucked it up and kinda did what I needed to do to get through. And just kind of exploded when I got back." Another soldier, Martin, began having panic attacks while in Iraq and sought help from the chaplain. "I tried my best to keep it low-key, so I told him like, 'I wanna see somebody but I don't want the unit to know.' And I thought that was it, I was just going to see the chaplain. I remember that one of the commanders came down to talk to me and I was like, 'I don't want to talk to *you* about it. And I felt bad, almost like I was doing something wrong. So I stopped going – you don't want people to think you're *weak*."

For the NCOs in the study, it was not uncommon to have been in charge of a soldier experiencing combat stress while deployed, and they, too, recognized the opposing forces of individual and unit needs. Carlos told me that, "A soldier will usually break down on their first deployment at least once. It's very common. They'll break down, and they just need a break. I had two or three who were a suicide concern, and you just send them back for a few days, give them a little break if you can. It's about all you can do, because we're short-handed. We had a rotation, and we'd be out on in the middle of nowhere for two weeks, and then we'll go back to camp for two days. So they'd get a little bit of extension. Everybody kinda thinks it's not fair,

but they kinda understand it too. Especially with the younger ones." There were too many needs requiring immediate attention. The unit's mission schedule competed for priority with the well-being of a soldier on suicide risk, which competed with the frustration of other soldiers at losing a member of the team. These concerns in turn competed with the understanding of supervisors who knew that combat stress was a pretty common thing, but who also knew that a short-handed team is a more vulnerable team. Carlos shrugged.

Letting Go of the Tough Guy

Although too cursory to fully represent the U.S. military's efforts to muster an effective response to PTSD, this chapter has dealt with the broad types of steps that the Armed Forces have taken, and suggested some of the opposing forces operating on military institutions and the individuals within them. On the one hand, the Department of Defense has found itself under pressure to hold onto its competent and expensively trained personnel, struggling to keep the Armed Forces at full readiness despite an almost universal recognition that the force is overstressed, and hemmed in by the need to keep negative public opinion about the military to a manageable minimum. This pressure has often resulted in the military's taking steps towards an active and aggressive response to PTSD and readjustment stress among service members. Military leaders have promoted better screening for PTSD and other mental health problems, providing greater access to clinicians, more effective treatments, and programs to minimize stigma around mental illness and care-seeking.

On the other hand, the cultural expectations of military life remain largely unchanged, with their emphasis on toughness, mission readiness, and the well-being of the group over the individual. Socialization to these values in military training (and perhaps also in one's youth, if

coming from a military family) are reinforced in an ongoing way within relationships with peers and leadership, and are undergirded by a 'boots on the ground' mentality that has only intensified as the conflicts have stretched on and the military has remained understaffed and overextended. Together, these social and structural pressures serve to perpetuate the stigma associated with mental illness, which is seen – effectively – as the inability to contribute to the well-being of the unit.

Much is at stake in this ongoing crisis. The life and well-being of service members struggling with combat stress. The well-being of units in combat, which may be weakened by the loss of individual members. The long-term goals of service members who want to stay in the military or maintain their security clearance for a future career. The relationships between a soldier and his buddies, unit, and leadership. The service member's own struggle to be a "perfect soldier" or Marine or airman or sailor. Individual service members are left tuning in to messages that urge them both to seek help and to suck it up, to take care of themselves and to sacrifice their own well-being for that of the group. So they diligently fill out the PDHA screening form, which diligently aims to find out whether they are in need of additional evaluation. And they lie.

Amidst such a flurry of conflicting pressures, the importance of the attitudes taken by those closest to a service member in trouble – often his buddies or direct leadership – seem to take on an added importance. They can push this uneasy balance in either direction, towards help-seeking or against it. Chris pointed out that it was his immediate superiors who kept him from committing suicide. "[T]hey took turns, at my house, in the chair next to my bed, making sure I didn't kill myself before they could get me on a plane. And my First Sergeant flew with me

halfway across the world and finally dropped me off in San Antonio three weeks later. He took three weeks out of his life, his family's life, to get me here."

In contrast, one Army clinician raised his hand in a workshop on PTSD treatment to say that he had had a difficult time even accessing troops while working in Iraq, because he kept running into irate commanders who told him that 'every time my people see you they come back wimpy and cry!' An Air Force clinician at the same workshop responded that he was summoned to speak with the unit commander the very day he landed in Iraq, and was told that he and his team would have full access to airmen because they were considered vital support.[84] He said that he even saw cases in which a guy's buddies accompanied him to the clinic. When thanked for supporting their friend, they would say, 'Well, this is what you guys do to help us complete our mission, right?' Thus the attitude towards care provided and received in the field varied widely, and had the potential to make a significant difference in who sought what care, when, and how.

These communicated ideas about illness (weakness) and masculinity (strength) obviously impact how service members go about seeking help in times of trouble, but they linger on to influence how veterans seek care as well. It was fairly typical to hear one of the veterans in the study say of care-seeking, as Carlos did, "I waited a long time - well, to me it seemed like a long time. I knew I needed to do it and I fought it and fought it and fought it." He gives a dry smile. "Course I had this military attitude, you know. Suck it up. Get the job done. Be the example. And you know I went through a lot of pain that was unnecessary because of

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[84] This likely reflects differences in the cultural values (and structural pressures placed upon) the Army vs. the Air Force. It appears to also be consistent with local variations in mission focus, attitudes towards mental health, and with the difference in leadership styles among individual commanders.

that. And of course admitting that you have a problem. I notice that's a problem for a lot of people. Letting go of that tough guy." Carlos did not suddenly stop being responsive to the messages he learned in the military when he began the transition into civilian life. Those messages were hard-won, and hard lost.

One last thought. For all the emphasis on communal life in the military, on the joy that service members may take in the camaraderie of their friends and the trust they may place (when it is earned) in their leaders, and on the satisfaction that can come in being part of a shared mission, it should not be glossed over how punishing can be the loneliness and self-doubt that arises with the fear of not being able to live up to the group's expectations.

In the Fall of 2007, I gave a presentation on the history of combat stress to a group of chaplains at BAMC. As I was standing around afterwards, eating a plate of buffet lunch, one of the chaplains came up and began chatting with me. He said his name was Jim and asked casually, although watching me very closely, 'So how are you doing with all this stuff?' I paused – although I suspected what was coming – and answered, 'Well, I had nightmares last night, if that's what you mean.' He snorted a little, and said, 'Yeah, well.' 'How about you?,' I asked, 'How are you doing with this stuff?'

And he started talking about how he was struggling. He said that he had been to Iraq twice, and on the very first day he had 'seen stuff' and thought to himself, 'Oh God, what am I in for?' He said that the other chaplains didn't want to talk about it; they didn't even want to hear about it. He said that there is a lot of 'emotional stuffing' going on, of people trying to pretend everything is fine. He started to say more, but his supervisor walked up just then and he stopped talking. We chatted for a little bit; the supervisor asked if I thought there was a military culture. Jim chimed in, reaching out and putting his hand on his supervisor's shoulder. He said,

'Oh yeah, because we're both in the Army, [he] and I are like brothers, no matter what the differences between us.' His supervisor gave a short nod, damningly slight. Then, after a few minutes, he abruptly said that he and Jim had to get back to work, and the two of them shook my hand and went off together.

I ran into Jim a few minutes later as I was heading towards the exit, and we walked down the long hall, side by side. I noticed he was keeping one eye out as to who was around us as we went. He said that he had found himself talking to a bunch of soldiers one night, after they had had a casualty in his unit, and they said, 'We can always go to you, Chaplain, when we need help. But who do you go to?' He said, 'I gave the Chaplain's answer, which is, 'I go to God,' but…' and he shook his head. I asked if he had been able to find the kind of support he needs, now that he was home. He said yes, that he has gotten some counseling – here his voice got very quiet – and that he has his church community, with whom he is trying to be as naked and an honest about himself as he can be. He put his hands to his chest as he said this, looking down. We realized that we were both headed back downstairs, so we took the elevator down together, not talking now that there were others around, and said our goodbyes on the ground floor. I suggested some additional resources available to him, and asked him to call if he ever thought there was anything I could do. As I walked out to my car, I thought back on how eager he had seemed for the chance to talk, even if only muttering in the hallway with one eye cocked to see who else might be listening.

Embattled

The Clinic, Part I: The Politics of PTSD in VA Mental Health Care

Chapter Six

A Commitment to Service

I was sitting by the entrance of the local VA's Trauma Clinic one morning when a middle-aged Latino man came walking up the main stairway from the lobby, looking a little lost. He wore glasses and an oversized black t-shirt with flames and the name of an auto part store on the back. I asked if I could help and he told me he was looking for Mental Health. I gestured toward the door, then smiled and pointed to where the sign was hidden behind an event poster. He grinned and thanked me, and as he walked over to the door, he said, his smile fumbling sideways a little, 'I hope they can help me before I go completely crazy.'

Helping those in distress is the mission of VA mental health clinics all over the country. Under the sprawling jurisdiction of the Veterans Healthcare Administration, local VA hospitals and clinics across the U.S. provide mental and physical health services to veterans of all ages. Determining who is eligible for such care can be tricky, but the criteria can be briefly summarized as follows: most veterans who meet low-income requirements will receive free care at the VA for any condition, and most veterans who have one or more service-connected

illnesses or injuries will receive free care for those conditions.[1] Healthcare is only one of the services that the VA provides; other rights and resources include disability compensation, rehabilitation services, home loans, education assistance, and burial in a national cemetery.

All of these services are of a piece with the larger objective of the VA. The main VA hospital in San Antonio is an expansive brick building located to the northwest of the downtown area. Just inside the main entrance, beneath the plastic banner that welcomes OEF/OIF veterans into a lobby mainly populated by much older men, the VA's motto is written on the wall in black script: "To care for him who shall have borne the battle, and for his widow and his orphan…"[2] This motto is part of the ethos self-consciously sponsored by the VA in its treatment of veterans. Many of the clinicians wear ID badges on a lanyard that reads, "How May I Serve You?" and "Now It's Our Turn." There is a clear notion of honorable exchange, of services rendered; veterans have served their country, and the VA exists to serve veterans. At the same time, the lanyard is designed to break – allowing the clinician to escape – if grabbed too roughly by an angry or out-of-control veteran patient. It is an apt symbol of the relationship between veterans and the VA: a great deal of mutual respect and appreciation and just enough distrust to keep everyone on their toes.

In this chapter, I will explore the politics of PTSD as they emerge in a third cultural environment, the U.S. Department of Veterans' Affairs, asking: What responses has the VA put

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[1] Eligibility criteria for care at the VA are labyrinthine, with criteria based on period of service, length of service, military discharge status (for example, individuals who were dishonorably discharged may not be eligible), income, level of disability and/or unemployability, etc. For a breakdown, please see the VA's online Eligibility and Enrollment website for the most up-to-date information: http://www.va.gov/healtheligibility/eligibility/DetermineEligibility.asp

[2] The line is taken from President Abraham Lincoln's second inaugural address, given in March of 1865.

forward in reaction to veterans' post-deployment struggles? What historical, professional, and political economic forces have encouraged these responses to emerge in the form that they have? And, given that most veterans with PTSD are likely to pass through the VA in the course of their illness, how do these responses play a role in shaping veterans' attitudes towards PTSD treatment and diagnosis? In looking to answer these questions, I focus on one small but influential Trauma Clinic within the San Antonio VA Healthcare system.

Referral and Diagnosis

The Trauma Clinic itself is located on the second floor of an outpatient facility a mile or so from the main VA hospital, its waiting room just inside a solid wooden door off the main hallway. The clinic itself is institutionally neutral, walls covered in a mottled paper somewhere between grey and green. The waiting room contains vinyl chairs and a television that usually plays daytime talk shows, and is decorated with posters featuring military insignia and VA messages aimed at veterans of different eras (so that all will feel welcome). The clerks' office, where veterans register for appointments, is housed behind a glass enclosure to one side. There is a door from the waiting area to the main group room, a more welcoming space hung with paintings by veterans and framed news clippings about soldiers serving overseas. The rest of the clinic is oriented, for the most part, around one long hallway, with clinicians' office doors opening and closing along this axis. The air hums with muffled voices and the sound of footsteps on linoleum.

Although there are separate outpatient and inpatient services available locally for veterans with non-PTSD-related mental illness, the mission of this VA clinic is to provide

comprehensive mental health care for veterans who have been diagnosed with PTSD.[3] The Trauma Clinic, which in 2008 was one of 117 similar clinics providing outpatient PTSD services at VAs around the nation, employs about a dozen clinicians who work at least part-time within the Trauma Clinic, as well as additional psychology and/or psychiatry interns who provide supportive services.[4] Clinicians provide care for combat veterans of all ages and conflicts – from WWII, Korea, Vietnam, the First Gulf War, Iraq and Afghanistan – as well as for those whose trauma, such as military sexual trauma, may not have occurred in combat at all.

Within the Trauma Clinic, a team comprising one psychologist and one social worker was put together in August of 2006 to provide dedicated care for veterans of Iraq and Afghanistan. Other providers in the clinic may also see OEF/OIF clients, but the creation of a specialized OEF/OIF team was intended to offer services tailored to the needs of the most recent veterans. This move mirrored efforts across the VA system, locally and nationally, to respond to the changing needs of U.S. veterans after the wars in Iraq and Afghanistan got underway, when the VA was faced with an unexpected influx of much younger, more recent veterans. After decades in which the VA had focused on providing care to a population of aging men and women, it suddenly found itself having to provide for an entirely different cohort of veterans, many of whom had returned home from overseas with severe injuries or illness.[5]

Veterans generally came into the Trauma Clinic through a referral from either the VA's Emergency Triage clinic or the Primary Care clinic located on the floor below. I have already

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[3] Veterans receiving care at the Trauma clinic must also have at least one key trauma exposure that occurred during military service.

[4] (NEPEC, 2009)

[5] The upheaval created by these changes was reflected locally in the makeup of the clinic's staff; during the 18 months of the study, nearly half of the Trauma Clinic's staff moved on to non-VA positions, to retirement or private practice, or were shuffled between VA clinics undergoing periodic restructuring.

discussed those veterans who came into the VA seeking help because they were in crisis or because they suspected PTSD or another mental illness might be at the heart of their problems with post-deployment life. An equally important pathway into PTSD treatment for study veterans occurred via the VA's non-emergency referral system. Primary Care physicians regularly screen veterans – who may have come in out of concern over a specific mental or physical health problem or simply for a routine physical exam – for PTSD, substance abuse, depression, and other mental health concerns. It was not unusual for veterans in the study group to admit that they never associated their post-deployment problems with PTSD before they were referred to the Trauma Clinic for further evaluation.[6]

Veterans who are referred to the Trauma Clinic are given a diagnostic interview that collects information on their social history, past trauma exposure, alcohol and drug use, legal history, and psychiatric history. Structured assessments like the Clinician Administrated PTSD Scale (CAPS) are used to determine with the individual meets accepted criteria for a PTSD or other diagnosis. After this interview, the veteran may be given a preliminary diagnosis (or more than one, if the individual appears to meet criteria for several conditions). If diagnosed with PTSD, the veteran will usually be referred to one or a combination of several outpatient treatment options available at the Trauma Clinic; inpatient care is generally reserved for those considered to be actively psychotic or at imminent risk of suicide or homicide. Outpatient services available at the Trauma Clinic include case management, group or individual therapy

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[6] As noted in Chapter Four, some of these veterans only sought an initial appointment with Primary Care as means of initiating their relationship with the VA, or of seeking care or compensation for an injury sustained while in the military. For these men, referral into the Trauma Clinic often came as a surprise.

sessions, psychoeducation classes dealing with specific skills training in Anger or Stress Management, and the prescription of psychotropic medications by on-site psychiatrists.

But while the job of the VA Trauma Clinic is primarily to provide quality mental health care to veterans with trauma-related mental illness, its clinicians may find themselves doing far more than simply providing mental health care in accordance with their professional training. As federal employees and staff of the U.S.'s largest healthcare system, their actions are often viewed in relation to national debates around policy and practice. There are two debates, in particular, that frequently implicate VA mental health providers: first, the debate over whether veterans receive adequate care and compensation from the VA; and second, the debate over what kind of care (and compensation) is adequate and appropriate for PTSD.

In order to get a sense of these debates – and of the tensions they create for both veterans and for VA clinicians – let me begin by revisiting a Congressional Veterans' Forum that was held in San Antonio. In the shouting and speechifying that took place at that event, we find much of the explosive rhetoric that can turn treatment at the VA into a minefield.

The Keynote Congressman

In August of 2007, four U.S. Congressmen held a hearing to address the needs and concerns of local veterans, a meeting I learned about from a Vietnam veteran and his wife, Steve and Ellen, whom I had interviewed twice in the preceding weeks. Steve served in Vietnam prior to their marriage, and had suffered from increasingly debilitating mental health and neurological problems ever since. He and his wife had spent years wrangling with the VA's Compensation and Pension (C&P) office in an attempt to get the VA to recognize their claim that

his health problems were a result of two years in Vietnam. In addition, two of their children had served in Iraq and returned home with difficulties.

During our first interview, Ellen wrote a long note on a scrap of paper while I spoke with her husband. It began:

> PTSD – not recognized with
> my husband/Vietnam
> made to feel he had
> to handle it on his own
>
> our lives suffered immensely from this

She went on to pour forth the multigenerational suffering that war had brought into her family – her husband's drinking and violence, then later her children's many deployments as soldiers themselves, and the problems these absence had created for her grandchildren. She linked this suffering with what the VA did not do: diagnose Steve with PTSD across all the decades of their struggle. "Our lives suffered immensely from this," she wrote, because he was "made to feel he had to handle it on his own."

Fueled by this history, the pair have become eager advocates for veterans' rights, hence Ellen's insistence that I should attend the Forum. The event was held in a large theater/auditorium at a local university, and when I arrived, I wove past a handful of official-looking young staffers to find the two of them perched in one of the few empty spaces left in the packed theater, crowded in among several hundred other veterans and family members. Steve was in his motorized chair that day, looking – as ever – handsome and diminished by illness. Ellen was beside him, crouched sitting on her own walker, her usual energy drink clutched tightly in one thin and freckled hand, as restless and intense as her husband was distant, disoriented.

I said hello to Steve and then Ellen and I chatted as the Forum began. A group of local veterans marched down the auditorium steps bearing the American flag and placed it with due formality on the stage at the front of the auditorium. A moderator in Air Force blues took the podium and introduced each of the Congressmen present. Three local representatives each took the podium and gave brief comments, leading up to what was clearly intended to be a keynote presentation by the fourth Congressman, who was then serving on the House Committee on Veterans' Affairs. The local representatives pointed out a series of problems with VA services that had been covered recently in the national media, including gaps in VA healthcare related to the influx of OEF/OIF veterans and the need to develop appropriate care systems for dealing with PTSD and Traumatic Brain Injury (TBI). They each made a case for their own track records in standing up for veterans. Ellen cackled irreverently next to me, cynical and unimpressed.

When his turn came, the Keynote Congressman got up and was greeted with a standing ovation. He said his thanks and then pointed out that getting four Congressmen in the same room for an event like this was a rarity, calling the occasion evidence of their 'unity on behalf of all veterans.' This prompted another round of applause; the crowd was primed and responsive. He spoke about Walter Reed, saying that the scandal, though focused on military healthcare rather than the VA, had helped Congress to 'figure out that we aren't doing enough,' a statement greeted by a chorus of 'Yeah!'s from the audience. He said that Congress had since been taking a much more aggressive stance on veterans' issues, demanding 'the money we need to take care of our veterans!' And as evidence of Congress' efforts, he cited a 30% increase in the VA budget for the 2008 Fiscal Year. Even so, he said, the VA had too often stood for 'Veterans Adversary' rather than 'Veterans' Advocate.'

Having delivered this salvo, he turned to talking about how divided members of Congress had been in their views on the war in Iraq, and contrasted this with their unity in support of providing for veterans. He hesitated for a minute, then asked the audience, 'How many of you are Vietnam veterans?' The majority of the audience raised their hands, and he looked at them for a minute, held a perfect pause, and said, 'I have two things to say to you: Thank you. And I'm sorry.' Thank you for your service. I'm sorry for the care and thanks you didn't receive when you came home.

A mingled groan rose from the crowd in response – agreement and relief and fury. He went on, lambasting the moral disgrace of a nation in which there are homeless veterans. He called it shameful that there have been as many suicides among Vietnam veterans after the war as there were deaths in combat during the war itself,[7] at which the audience again gave voice, sending up murmurs of shock, disgust, and anger. He promised, 'Never again!' and cries of 'Never again!' went up amidst the clapping. He said that there are some veterans who are sick, who are fighting cancers, and who are made *more sick* because they are constantly fighting an

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[7] This statistic is repeated so widely as to have gained the status of a social fact, although I have been unable to locate any data to support its veracity. In 1990, one study estimated that – based on population-based mortality studies – fewer than 9000 Vietnam veterans had committed suicide, although claims ranging from 50,000-100,000 Vietnam veteran suicides were already circulating by the late 1980s (Pollack, Rhodes, Boyle, Decoufle, & McGee, 1990). The authors also found that relative risk for suicide among Vietnam veterans studied (as compared with other Vietnam-era veterans, nonveterans, and men in the general U.S. population) ranged from 0.93 to 1.46, but never came remotely close to the estimated 6x increase in suicide among Vietnam veterans that would be described by such extraordinarily high numbers as claimed. Bullman and Kang (1995) did report that, among Vietnam veterans in the Agent Orange Registry, veterans with PTSD were more likely to die of suicide, single vehicle motor accident, accidental poisoning, and other accidents than were other veterans or men in the general population. In contrast, Boyle and Decoufle (1988) found that, in a sample of 18,000 Vietnam era veterans matched with men from the general U.S. population, there was no apparent increase in suicide risk among veterans, although there was an 8% increase in motor vehicle mortality among those who had actually served in Vietnam. In other words, the data seem to support the conclusion that, while suicide rates among Vietnam veterans have historically been somewhat higher than among other veterans and non-veterans, they are unlikely to have ever been as high as suggested by claims of 50,000 or more veteran suicides.

unresponsive bureaucracy. There was huge applause at this, and Ellen stuck her skinny fist in the air and shouted, 'Yes!'

The Congressman then went to say that there are, 'Thirty to forty thousand people in the VA whose job it is to say you're a liar' – speaking of the VA employees who evaluate veterans' applications for disability compensation, which require the veteran to provide evidence that: a) he or she has a disabling injury or illness, and b) this is a condition resulting from military service. He offered a rebuttal to the status quo: 'You don't *have* to prove it! You served us!' He talked about Vietnam veterans as 'canaries in the coal mine' for the problems of the VA system, and apologized that 'we have not served you!' But then he turned to the problems faced by 'these young folks coming back,' describing the mental and physical health problems of Iraq and Afghanistan veterans and comparing their needs with those that went unsatisfied after Vietnam. He said seriously, 'We're going to try not to make the same mistake.'

His speech was succinct and well-spoken, although he said nothing that was dramatically new. When he was finished, the moderator tried to initiate a question and answer period, but it rapidly devolved into a shouting match featuring a handful of self-identified Vietnam veterans with PTSD, enraged at the treatment they had (not) received. There were several attempts to calm the assembled crowd and re-organize a more peaceable discussion, but this only became possible when the handful had said their piece. The Forum was brought to a close shortly thereafter, as one local reporter described it, "long before the audience was ready."[8]

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[8] (Hamilton, 2007)

The Congressman's speech was very much in line with broader American discourses around the benefits and services due to veterans in exchange for their service. It points to a widely shared sense of guilt over those Vietnam veterans who came home and were treated carelessly and without honor by a nation then torn in two over the conflict itself.[9] This sense of past wrongs came up frequently during my fieldwork, as when one woman who provides care for active duty military said vehemently, 'Shame on us if we ever let Vietnam happen again…' But although such sentiments were commonly expressed during this time period – in both local conversation and the national media – the necessity of repeating them seemed to emerge out of a sense that veterans might become invisible if the wars in Iraq and Afghanistan lingered on too long, if the emerging stories of distress and despair became too familiar. This was 2007, the same year that online PTSD advocate Ilona Meagher authored a book entitled Moving a Nation to Care. The implication seemed to be that the nation did not.

And so the VA of the 2000s was faced with two challenges for which it was unprepared. First, there was the sheer magnitude of the task of making services available to a new generation of service members returning from foreign wars in numbers and with conditions that the VA – after decades of focusing on the chronic illnesses of aging World War II, Korea, and Vietnam veterans – was not prepared to handle, including traumatic brain injury, PTSD, and severe wounds such as burns and amputations. VA clinicians, at least, were fully aware of how big the challenge was, and how much bigger it was likely to get. At a national VA conference I attended in April 2007, one of the speakers looked out over a room of several hundred clinicians and joked, 'This looks to me like our waiting rooms are going to look…' The VA was not planning

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[9] Michalowski and Dubisch (2001) offer a rich analysis of the meanings of the Vietnam war in contemporary America.

for a flood of new veterans when September 11th suddenly changed the stakes, and the VA of later years was struggling to keep up.

But beyond playing logistical catch-up, the VA was also faced with the symbolic task of trying to right wrongs done in the years after Vietnam. 'Caring for the troops' is more than an institutional mission. It is a contractual obligation of the U.S. government – a right given in exchange for military service. It is also a promise that, in the current era, falls always under the shadow of what looks to many like the betrayal of a past generation of veterans. 'Shame on us if we ever let Vietnam happen again…'

This, then, is the VA and its obligations writ large. There is a history of distrust between veterans and the VA that lives on in a vocal calling-out of VA failures, and there is a powerful need for the enormous bureaucracy to keep up with changing times.

For the individual veteran, however, the institution of the VA is generally embodied in the individual staff members he or she encounters (as well as in decisions handed down from disability claim adjudication boards whose members he may never meet). For mental health care providers at the Trauma Clinic – who already serve as the face of their various professions as psychiatrists, psychologists, and social workers – this adds a level of complexity to their daily clinical practice. They must be both clinicians *and* representatives of the VA, and at times this means their practice may be as political as it is professional. When they fail, as when VA clinicians in Minnesota turned away 25-year-old Jonathan Schulze only days before he committed suicide, those failures become national news. The 2007 *Newsweek* article describing Schulze's death was titled, "How U.S. is Failing Its War Veterans." [10]

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[10] (Ephron & Childress, 2007)

In preparation for exploring how Trauma Clinic providers attempt to fulfill this dual role, and the impact this may have on veterans themselves, it is worth taking a brief look back at the history of PTSD and at two lessons it can offer for today. First, this history reveals how PTSD came into being as the modern iteration of older views of combat stress discussed in Chapter Five (e.g. shellshock, combat fatigue, etc.), and as part of a coming-of-age in contemporary psychiatry. Second, it shows us that this is not the first time that mental health providers have found themselves at the intersection between professionalized clinical knowledge about combat stress and the political weight of veterans' well-being. In both lessons, we find a demonstration that the very way we recognize and name PTSD in modern America is inseparable from the political and professional past.

A Clinical History of Post-Traumatic Stress Disorder

American clinical ideas about combat stress, as discussed in the last chapter, arose in large part out of the need for military psychiatrists to help keep as many boots on the ground as possible during the bloody World Wars of the early 20th century. By the end of World War II, military psychiatrists had seen some important gains in their knowledge about combat stress. They had come to recognize that any individual, under the right circumstances, could be susceptible to combat stress.[11] An effective system of triage and care in-theater had been developed, and psychiatrists had gained an appreciation for the importance of unit cohesion in

[11] (Shephard, 2001)

preventing combat stress. They had also found that normalizing soldiers' experiences seemed to help in preventing an escalation of symptoms.[12]

Even so, WWII had importance for the future of combat stress beyond efforts to develop appropriate diagnoses and treatments. The demobilization of some 10 million men after the war helped to destigmatize mental illness in the post-war period, for the lingering idea that WWII era service members suffered no ill effects upon returning home does not entirely hold true.[13] The 1946 film "The Best Years of Our Lives" made an Oscar-winning attempt to document veterans' turbulent homecomings, telling the story of three veterans who return from years at war to find that homecoming was far more complicated than they had dreamed, falling back upon alcohol, isolation, and the solace of other veterans in their efforts to re-enter civilian life. By 1947, the VA was providing pensions for neuropsychiatric disabilities to nearly half a million veterans.[14] There were other significant changes in national policy, including the National Mental Health Act of 1946, which provided for the establishment of community-level mental health clinics, as well as funding to support research into the causes and treatment of

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[12] There was also some recognition that "combat fatigue," as combat stress was then called in an effort to remove some of the stigma of the older "war neurosis," came in several forms. Lt. Col. Brian Chermol has distinguished three types in particular.[12] The first of these was a nondisabling form of 'fatigue' that was seen almost universally across combat units, including symptoms of exaggerated startle, sleep disturbance, and mild somatic complaints (and which sounds not unlike elements of what the military calls "readjustment" today). The second was a severe but temporary form occurring early in the individual's exposure to combat, signified by tremors and shaking, panic, sudden deafness or muteness, and gastrointestinal symptoms such as vomiting and diarrhea. And there was what came to be known as "Old Sergeant's Syndrome," a condition of exhaustion and "burn-out" in which the most combat-hardened soldiers demonstrated decreased movement and response to stimuli, as well as depression, increased aggression, tremors, and fatalism. While the first two forms were typically responsive to short periods of rest and rehabilitation, "Old Sergeant's Syndrome" proved more intractable and difficult to treat (Wanke, 1999).

[13] (Nisbet, 1945; Wanke, 1999)

[14] (Shephard, 2001)

neuropsychiatric disorders and the creation of the National Institute for Mental Health (NIMH).[15]

However, it wasn't until the early 1970s, in the aftermath of another war, when it became widely accepted in the media and in professional circles that Vietnam vets were succumbing in record numbers to mental illness, substance abuse, and suicide.[16] Many authors have attempted to explain how Vietnam became the conflict that redefined war trauma for the psychiatric community, despite the fact that psychiatric casualty rates during the conflict's early years were at an all-time low. Psychiatric casualty rates were as high as 101 per 1,000 troops in WWII, dropping to 37 per 1,000 in Korea and 12 per 1,000 in the early years of Vietnam.[17] The conflict in Korea, moreover, had provided the opportunity for military psychiatrists to perfect their system for responding to soldiers' distress, treating psychiatric casualties close to the front, as quickly as possible, and with the expectation that recovery would be swift and men would return to the front.[18]

Nonetheless, by 1973, Robert Jay Lifton had published the influential book Home from the War, which described the suffering of Vietnam veterans. He began one chapter with the provocative statement, "Everyone who has contact with them seems to agree that they are different from veterans of other wars".[19] The source of this difference was unclear. Some said it was the lingering disappointment of losing a highly unpopular war. Some blamed the draft,

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[15] (Rochefort, 1997); There were other important developments during the post-war period. Cases of traumatic neurosis that developed long *after* combat exposure began to be documented in the clinical literature, and new drugs such as Valium became available for the treatment of anxiety (Wanke, 1999).
[16] (Young, 1995)
[17] (Shephard, 2001)
[18] (Shephard, 2001)
[19] (Lifton, 1992[1973]: 35)

others the intense nature of the guerilla conflict in-theater. Others laid responsibility on the widespread rejection of Vietnam veterans upon the return home, or on those who blamed veterans for the atrocities committed at My Lai and elsewhere.[20] In the wake of this controversy, a number of clinicians and veterans' advocates joined forces to promote formal recognition of what was originally called "post-Vietnam syndrome" – a cluster of symptoms including guilt, rage, numbness, and alienation – as a hitherto undiagnosed and untreated mental illness.

These advocacy efforts from veterans' groups and allied mental health professionals might have proven less effective if they had not been conveniently timed to coincide with a radical shift then rocking the foundations of modern American psychiatry.[21] Up until the 1970s, psychiatric diagnosis had been considered something of an interpretive art. The American Psychiatric Association's (APA) manual of the field, the Diagnostic and Statistical Manual of Mental Disorders (DSM), provided lengthy descriptions of each recognized diagnosis, with a heavy emphasis on those, like the neuroses, that had come down through the Freudian psychoanalytic tradition. In the late 1970s, however, a psychiatrist named Robert Spitzer was heading up a sweeping re-construction of the DSM in preparation for its third edition. The goal was to provide a list of key symptoms for each diagnosis, so that psychiatrists around the country could identify a diagnosis in terms of whether it met specific criteria – going down a checklist of sorts – rather than based on their own interpretation of the patient's experience. It was an attempt to standardize psychiatric diagnosis in an entirely new way.

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[20] (Lifton, 1992[1973]; Shephard, 2001; Young, 1995)
[21] (Scott, 1993)

As this profession-changing DSM was being readied for publication, several clinicians approached the DSM committee to request that post-Vietnam syndrome be considered for inclusion in the new volume. As anthropologist Allan Young has described it, the committee's chair, Robert Spitzer, was initially reluctant, but decided to put together a working committee to investigate the disorder, swayed by the political sensitivity of issues related to veterans' mental health.[22] Once assembled, the working committee was also reluctant to officially adopt the disorder. There was little epidemiological research to support the idea that post-Vietnam syndrome represented an experience distinct from other mental illnesses, and a number of psychiatrists argued that the disorder's symptoms could be accounted for by pre-existing diagnoses such as depression and anxiety. The only thing that was unique about the syndrome, argued these psychiatrists, was the idea that it could be caused by a particular event – a trauma.

Young has illuminated several arguments that ultimately convinced the DSM-III committee to adopt the diagnosis, re-named "Post Traumatic Stress Disorder" or PTSD. First of all, there was clinical evidence stretching back to the 19th century that seemed to identify a consistent neurosis or stress condition arising after experiences of trauma (including rape or child abuse as well as combat). In addition, no research funds had been available for the study of PTSD until that time, as the diagnosis was not yet recognized by the APA, and so it seemed unreasonable to expect that there would be epidemiological evidence to either support or refute the existence of PTSD as a distinct phenomenon. Also, there were moral reasons for creating a formal PTSD diagnosis. Since many of those who fought in Vietnam had gone unwillingly, recruited by the draft and sent off to wage an unsuccessful war, there was a sense

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[22] (Young, 1995)

that their suffering was the more grave for having been involuntary and futile. Young suggested that:

> The failure to make a place for PTSD would be equivalent to blaming the victim for his misfortunes – would mean denying medical care and compensation to men who, in contrast to their more privileged coevals, had been obliged or induced to sacrifice their youths in a dirty and meaningless war.[23]

Many of the physicians and other advocates responsible for making the decision about PTSD had, by virtue of their education, escaped the draft and avoided the war, an uncomfortable irony that no doubt shaped the deliberations.

Thus, Young has argued that PTSD as a formally recognized psychiatric disorder came about in large part as the result of political processes rather than scientific ones. The diagnosis was officially adopted because it was thought that the suffering of Vietnam veterans should be recognized, not because any evidence existed at that time to suggest that PTSD represented a wholly new disorder.

Regardless, PTSD was included in the 1980 publication of DSM-III, and in that same year, was approved by the U.S. Congress as a disorder for which veterans could receive compensation through the Veterans' Administration.[24] PTSD was unique in being the first environmentally determined mental disorder ever accepted by the psychiatric community, with a causal model presuming symptoms were the result of a "traumatic event" that "would evoke significant symptoms of distress in almost anyone".[25]

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[23] . (1995: 114)
[24] (Young, 1995)
[25] (quoted in Young, 1995: 117) Because it was defined among veterans, most of whom had been out of the service for years, PTSD described a phenomenon quite different from that which had brought earlier psychiatrists to write about shell-shock and combat fatigue – the diagnosis bore more resemblance to "Old Sergeant's Syndrome" than to the acute cases that first garnered attention in WWI.[25,25,25]

Table 6-1. Current Diagnostic Criteria for Post-Traumatic Stress Disorder (DSM-IV)[26]

A person must have been exposed to a traumatic event.
The event involved a perceived or actual threat to the person's own life or physical integrity or that of another, such as a physical or sexual assault, rape, a serious accident, a natural disaster, combat, being taken hostage, torture, displacement as a refugee, sudden unexpected death of a loved one, and witnessing a traumatic event.
The person's response to the event involved fear, helplessness, or horror.
The person persistently reexperiences the event in at least one of several ways:
The person has intrusive recollections of the event.
The person has nightmares.
The person has flashbacks, which are particularly vivid memories that occur while he or she is awake and make him or her act or feel as though the event was recurring.
The person has intense psychological distress in response to reminders of the traumatic event.
The person has intense physiological reactions in response to reminders of the event (including palpitations, sweating, difficulty breathing, and other panic responses).
The person avoids reminders of the event and has generalized numbness of feeling, as indicated by the presence of at least three of the following:
The person actively avoids pursuits, people, and places that remind him or her of the event.
The person avoids thinking of or talking about the event.
The person is unable to recall aspects of the event.
The person has lost interest in or participates less in activities.
The person has felt detached or estranged from other people since the event.
The person has a restricted range of emotions or a feeling of numbness.
The person feels as though his or her life has been foreshortened or as though there is no need to plan for the future, with respect to his or her career, getting married, or having children.
The person has symptoms of increased arousal, as evidenced by the presence of at least two of the following:
The person has difficulty falling or staying asleep (sometimes related to fear of having nightmares).
The person is irritable and has feelings or outbursts of anger.
The person has difficulty concentrating.
The person has become more vigilant and concerned about safety.
The person has exaggerated startle reactions in response to sounds or movements.
The three types of symptoms must be present together for at least one month.
The disorder must cause clinically significant distress or impairment in social, occupational, or other areas of functioning.

*There are three subtypes of PTSD. Acute PTSD refers to symptoms that last less than three months. Chronic PTSD refers to symptoms that last three months or longer. Delayed-onset PTSD refers to symptoms that begin at least six months after a traumatic event. Adapted from the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition.[3]

Within a year, PTSD had moved from a non-existent diagnosis to an accepted disability for which lifelong compensation was available to qualifying veterans. [27]

By the late 1980s, the diagnosis of PTSD had been internationally embraced, having morphed in the process from a "war neurosis" to a phenomenon of the general population.[28]

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[26](Source: Yehuda, 2002b)

[27] While the criteria for diagnosing PTSD have been revised in more recent DSM editions, the overall symptom set has remained largely consistent with the psychological symptoms described since the Civil War: restlessness, sleep disturbance, recurrent memories and nightmares, aggression, hypervigilance, exaggerated startle response, etc. Many of the somatic symptoms that received early attention – gastrointestinal distress, pain, heart palpitations, etc. – seem to have fallen off this list. This may be due to the fact that the veterans on whose experience the PTSD symptom list was based were no longer undergoing the same terror and physical exhaustion typically experienced by soldiers during acute stress events; this may also reflect a tendency in American psychiatry to separate out physical symptoms as 'somatization' of a mental problem rather than an essential piece of the problem itself.[27,27]

The diagnosis of PTSD was increasingly given to survivors of non-combat traumatic experiences, including childhood abuse, rape, motor vehicle accidents, natural disasters, and so forth.[29] In 1995, Kessler and colleagues screened 8,098 randomly sampled participants in the U.S. and found that 7.8% of them (far higher than the psychiatric casualty rates cited from Korea or the early years of Vietnam) were experiencing PTSD as a result of child abuse or involvement in a life-threatening event.[30] This broadened understanding of traumatic stress has been argued to reflect one of the great successes of the feminist movement because it acknowledged women's psychological distress following rape and family violence alongside the suffering of (until recently almost exclusively male) combat veterans.[31] But the broadening was also, in many ways, a product of the Holocaust; survivors of Nazi concentration camps were found to suffer distress similar to that of combat veterans, even decades afterward.[32,33]

Best Practices

Throughout the 1980s, as PTSD was evolving into a formalized disorder, the VA was in crisis. Phillip Longman's fascinating book on VA healthcare – not irrelevantly titled Best Care Anywhere: Why VA Health Care is Better Than Yours – starts with this passage:

> Quick. When you read "veterans hospital," what comes to mind? Maybe you recall the headlines about the three decomposed bodies found near a veterans medical center in

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[28] Although this was not the first time civilians had been susceptible to a PTSD-like phenomenon; see Young's (1995) discussion of 'railway spine.'
[29] Although this acceptance has not been without continuing controversy. For an articulate critique, see (Summerfield, 1999).
[30] (Ronald C. Kessler, et al., 1995)
[31] (Herman, 1992)
[32] (Shmotkin, Blumstein, & Modan, 2003)
[33] It is perhaps ironic that PTSD as a diagnosis began with veterans and ebbed outwards toward civilian forms of trauma, whereas the most effective treatments for PTSD were pioneered among civilian patients and only later brought into the VA.

> Salem, Virginia, in the early 1990s. Two turned out to be the remains of patients who had wandered off months before. The other patient had been resting in place for more than fifteen years. The Veterans Administration admitted that its search for the missing patients had been "cursory."
>
> Or maybe you recall images from movies like *Born on the 4th of July*, in which Tom Cruise plays an injured Vietnam vet who becomes radicalized by his shabby treatment in a crumbling, rat-infested veterans hospital in the Bronx. Sample dialogue: "This place is a fuckin' slum!"[34]

From such an inauspicious beginning, Longman goes on to describe the series of health care delivery crises that led the VA to develop its abysmal reputation. Established in 1921, in the wake of World War I, the U.S. Veterans' Administration faced its first scandal only four years later.[35] The head of the VA (at that time called the Veterans Bureau), Colonel Charles R. Forbes, was found to have wasted or stolen $200 million dollars in taxpayer funds (some $2.1 billion dollars in current money). Stunned by the sheer size of Forbes' graft, VA leadership attempted to prevent future pillage by building a daunting structure for financial oversight, with the result that by 1945 journalists were accusing the new director of tying the bureaucracy up in "needless red tape."[36] Following World War II, things became better for a while. The VA was newly empowered by the GI Bill to provide generous housing and education benefits, and changes in its organization allowed veterans access to some of the finest clinicians and researchers in the country.[37]

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[34] (Longman, 2007: 1)
[35] (Shephard, 2001)
[36] (Longman, 2007: 14)
[37] The VA was headed up by Omar Bradley during this period, who initiated the VA's close relationship with medical schools by offering that VA hospitals could serve as a training site for interns and residents (Longman, 2007).

But what Longman calls the VA's "golden moment of high public esteem" did not last.[38] The VA faced significant budget cuts in the 1950s. Facilities became understaffed as clinicians were laid off in droves, and new legislation left fewer veterans eligible for care. A series of exposés involving the careless treatment of research subjects gave rise to suspicions that veterans were being used as guinea pigs. When the Vietnam conflict began and veterans began returning from service, many of them encountered woefully underfunded hospitals and doctors and staff who – like so many Americans – were opposed to America's role in Vietnam. Declining conditions at the VA became a target of fury among veterans enraged by a government that they felt had used them and then left them to rot.

Even as the VA was increasingly dismissed as an antiquated and failing healthcare system, however, movements within the VA were laying the foundation for efforts that would – thirty years later – earn the VA recognition as a system of innovative and high-level care, with some of the best patient outcomes of any private or public healthcare provider in the U.S.[39] Employees within the VA, for example, developed open-source hospital information software called VistA that gave VA staff unprecedented electronic health records. Unlike other insurance and managed care systems in the U.S., the VA has patients for life, so the institution benefits from providing quality preventive care over the long-term, rather than focusing on acute care solutions, for example, as do employer insurance plans with a high turnover rate.[40] Although

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[38] (Longman, 2007: 15)
[39] (Longman, 2007)
[40] The patient-tracking power of VistA made it possible for VA physicians to investigate the health outcomes of patients treated using particular drugs or procedures, and therefore to determine the effectiveness of these treatments on a grand scale. (Longman points out that many Americans fail to realize how much of medical practice is based on anecdotal and experiential knowledge passed down through clinical training, rather than the accumulation of scientific evidence).

the VA was, by the 1990s, vastly overbuilt to support a dwindling population of older veterans, these pre-existing strengths made it possible for a new Under Secretary for Health in the VA, Kenneth Kizer, to come in and re-focus VA efforts on measuring patient outcomes and emphasizing health care quality. The accumulation of these efforts was so dramatic that, by 2003, the VA was the highest-ranked of *any* health care system in the U.S. according to the National Committee for Quality Assurance.[41]

Unfortunately for the VA, by 2003, national attention was not on celebrating the VA as a model for socialized medicine already working within the U.S. In 2003, the U.S. was going off to war in Iraq, and when the VA began to make the news again, it would be for very different reasons. There were a series of highly public problems at the VA after OEF/OIF veterans began returning home, many resulting in litigation. A 23 year old Marine, Jeffrey Lucey, committed suicide after getting back from Iraq in 2004. His family blamed the VA for their son's death, which came only three weeks after clinicians at the Northampton VA Medical Center refused to assess him for PTSD until he got his drinking under control; the family later sued for negligence.[42] In 2006, a class-action lawsuit was filed against the VA after an employee's laptop was stolen, giving the thieves access to personal information, including Social Security numbers, for more than 26 million active duty military personnel and veterans.[43] Then the Walter Reed scandal struck in 2007, beginning with an excoriation of healthcare within the Department of Defense but taking the VA Secretary down with it before it was over.

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[41] (NCQA, 2004)
[42] (McAuliffe, 2007)
[43] (Frieden, 2009)

The message was clear: the VA, like the military, was going to have to make good in taking care of this new generation of veterans. And in the public imagination, they were starting from behind.

Conflicts in the Clinic

When I began fieldwork at the VA in early 2007, about the same time as the Walter Reed scandal was breaking, the Trauma Clinic was in the middle of a revolution in both its organization and its treatment plan for PTSD – changes based on a fundamental shift in the way that clinicians were seeing and responding to PTSD. This was a transition several years in the making. New leadership had taken over the Trauma Clinic in the mid-2000s, and with the new leadership came a new perspective on how the Trauma Clinic should view its responsibilities as a care provider. It is not an exaggeration to say that this new perspective may come to revolutionize what PTSD means for veterans across the foreseeable future. It has the potential to prompt a profound change in the way that veterans live with (or without) PTSD. On the other hand, it may also fail horribly, drowning in its own risks and political ramifications. Understanding just how much is at stake requires some discussion of therapeutic technologies for PTSD.

Prior to the change, PTSD patients – generally veterans from WWII, Korea, and Vietnam – came into the clinic, became part of its long-term care program and, for the most part, never left. The Clinic's psychologists and social workers focused on providing supportive care through psychodynamic "talk" therapy, offered individually or in groups, while psychiatrists were primarily responsible for overseeing the prescription of appropriate psychotropic medications. PTSD is one of those contemporary psychiatric disorders for which a variety of drugs can be

effective in helping with side effects (reducing suicidality with anti-depressants, aiding in sleep, reducing the frequency of nightmares, etc.), but for which drugs have proven to be less effective over the long-term than certain psychological therapies.[44] This was the status quo for the clinic, as it was for clinics all over the country.

The therapy provided during this period, which extended from the founding of the clinic in 1989 to the mid-2000s, was diverse enough that it is difficult to characterize, although it is fair to say that it was overall more psychodynamically-inclined than would later be the case. In other words, psychodynamic clinicians active in the Trauma Clinic during this time offered individual and group therapy sessions aimed at helping the veteran to develop better skills for functioning in the world. The therapy itself was eclectic, often drawing on a combination of theories and therapeutic styles based on the individual clinician's own training and preferences. For example, one clinician described a strong reliance on Jungian analysis, while another was extensively trained in the use of hypnosis. There were commonalities, however. Therapy was understood to require time. One clinician described a handful of cases with positive treatment outcomes, all of which had taken several years to come to fruition. In our interviews, psychodynamic clinicians often used metaphors of loss in speaking of PTSD: loss of trust in the self, loss of trust in the world, loss of innocence. They relied upon a language for describing PTSD that drew heavily on concepts like the ego and the self, on listening, empathy, guilt, and shame.

But a revolution was brewing. As this older generation of clinicians – most of whom had been trained when PTSD was a fledgling diagnosis and who can speak at length of the VA's

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[44] (IOM, 2007)

earliest efforts to provide PTSD treatment in the 1980s – grew closer to retirement, a newer generation began coming in and gaining control. This newer generation noticed problems with the way the clinic was being run. There was a 1 to 2 year backlog for getting new patients into treatment. The number of patients had steadily accumulated over time, while the number of clinicians was roughly static. There were no time limits on any of the treatments the clinic provided, and there was no agreed-upon way of evaluating when it was time for a patient to move on. As one clinician described it, there was a 'culture of chronic support and treatment.' This clinician was quick to point out that there are benefits to such an approach – ongoing care for those who need it being one of them – but acknowledged that this plan proved unsustainable over the long-run in the absence of a continually expanding staff.

As OEF/OIF veterans began to come into the clinic seeking help, political pressure mounted to ensure that the new veterans received prompt and effective care and the backlog itself became unsustainable. In an effort to address the problem, the clinic's new administrators hired several fee-based social workers and psychologists to do nothing but intake interviews for a while, routing new patients into services at the Trauma Clinic or – if PTSD was not the main concern – into the adjacent mental health outpatient treatment center. Then the OEF/OIF team was formed, and new attention was paid to getting recent veterans into care as quickly as possible.

These and other organizational moves were only the beginning. The second and larger shift was one that cuts to the heart of how clinicians understand psychological trauma itself. As

I spoke with Trauma Clinic staff in early 2007,[45] clear boundaries had already coalesced around this issue, largely along generational lines.[46] As the older clinicians neared retirement or made the decision to move on (some prompted by the changing ethos in the clinic, if the comments of two departing clinicians are any indication), an effort was made to hire clinicians trained in clinical psychology and Cognitive Behavioral Therapy, focusing on those conversant with the relatively new and comparatively short-term evidence-supported treatments, or ESTs.

It is important to note that both psychiatrists and psychologists within the Trauma Clinic expressed support for the shift towards ESTs, perhaps because it arose out of a movement within clinical psychology that has emerged alongside Biomedicine's movement towards evidence-based medicine. Both are founded on the central assumption that treatment modalities should be judged on scientific evidence – read: their ability to consistently produce positive health outcomes in clinical trials – rather than on the accumulated experience of individual providers or the theoretical orientation of professional schools of thought. Psychiatrists at the clinic openly acknowledged that, while certain medications can be helpful in minimizing PTSD symptoms, no pharmaceutical treatment has yet emerged that is as successful in reducing PTSD severity over time as the CBT-based therapies.[47] So, while there were differences in viewpoint among providers at the Trauma Clinic, these differences did not fall

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[45] I was fortunate enough to interview the majority of these clinicians, as well as a dozen other non-VA clinicians working in the San Antonio area (total n=28), and both VA and non-VA clinicians were incredibly generous with their time in supporting this research. Nonetheless, I have pulled back from describing these debates and the more local politics involved with them in too much detail, out of concern that doing so might compromise these clinicians' confidentiality or their ability to practice at the highest capacity.

[46] The importance of this new generation of clinicians should not be underestimated, and not just for their role locally. One clinician described attending a national VA conference on PTSD where the audience of several hundred was asked to raise their hands if they had worked at the VA for five years or less. About half of those present raised their hands.

[47] (IOM, 2007)

along neat disciplinary lines. Because it is primarily psychologists who are responsible for directing group and individual therapies at the clinic – whether psychodynamic or cognitive behavioral – I found psychologists were typically the most direct in stating their feelings about ESTs. However, psychiatrists and social workers, who often work alongside their psychology colleagues in providing or supporting such care, also remained vocal and influential participants in the ongoing shift.

Among clinicians, the area of most active debate was related to the question of whether Prolonged Exposure therapy is an appropriate treatment for combat PTSD. Prolonged Exposure therapy, commonly known as PE or just exposure therapy, is a form of Cognitive Behavioral Therapy developed by Edna Foa and colleagues for the treatment of PTSD. It has been the focus of a significant amount of research over the past 20 years, and is one of only a few therapies determined in a 2007 Institute of Medicine report to demonstrate clear effectiveness in reducing symptoms of PTSD.[48]

Briefly, the model of PTSD underlying exposure therapy goes like this: PTSD comes about as the result of an individual's learning to avoid danger out in the world. Thus, when a trauma occurs, the circumstances surrounding that trauma are imprinted on the memory in such a way that those circumstances become associated with high levels of physiological arousal and anxiety – an evolutionary mechanism intended to help the individual avoid similar dangers in future. As a result, individuals with PTSD, when confronted with sensory stimuli that remind them of previously encountered dangers, will try to avoid them. This gives rise to the idea of

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[48] (for example, Bryant, et al., 2008; Creamer & Forbes, 2004; Foa, et al., 1999; Foa, et al., 2005; Foa & Rauch, 2004; Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Glynn, et al., 1999; IOM, 2007; Mason, et al., 2002; Rauch, Defever, Favorite, Duroe, & Garrity, 2009; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Schnurr, et al., 2007; Slagle & Gray, 2007; Taylor, et al., 2003)

'triggers,' or sensory reminders of past events. Such avoidance can be manifest in an obvious behavioral way, as in the case of avoiding Walmart because of the crowds. Or the avoidance may be experienced as a kind of emotional numbing, as when Jesse's uncle died and he was disconcerted to find that he felt no grief.

Exposure therapy rests on the principle that traumatic lessons learned in the past cannot be relearned to accurately reflect the current environment – for example, a veteran cannot learn that crowds at the Walmart in San Antonio do not pose the same threat as a marketplace in Baghdad – unless avoidance is overcome and there is sufficient exposure to the trigger that the individual "habituates."[49] Therefore, if the veteran who is frightened of crowds is forced to go to Wal-Mart and spend some time walking around (a technique called "in vivo" exposure), two things are thought to happen. First, he will re-learn that crowds do not necessarily equal danger (something he probably knew prior to Iraq). Second, the anxiety associated with the crowds trigger will be lessened because high levels of anxiety cannot be maintained forever in the absence of a perceived threat. It is not possible to stay continuously at the same high level of alert tension; over time, the body and mind habituate, and relax.[50]

This same principle is applied to dealing with memories. It is thought, under the PE model, to be the *avoidance* of painful memories that results in their uncontrolled intrusion into dreaming and waking life. And so exposure therapy requires that the individual spend extended amounts of time revisiting traumatic memories in extreme detail, remembering the smells,

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[49] Those familiar with the concept of "desensitization" will recognize the exposure therapies for their roots in this older technique. Edna Foa was herself trained in desensitization in the 1960s, but has continued to refine the original model over the past several decades.

[50] Relaxation training is also an essential part of the exposure therapies. The overarching idea is that learning to face anxiety teaches the individual to understand that he controls his own anxiety, not vice versa. Learning to practice techniques for relaxation supports this larger goal.

sights, sounds, and thoughts that occurred at the time of the event. There are different techniques to this – for example, the story may be spoken aloud and audio-recorded or put down in writing – but a key component is that the memory be revisited again and again until the anxiety associated with it diminishes. The standard program for PE last between nine and twelve weeks.

For those swayed by the scientific evidence supporting the efficacy of exposure therapy, as well as the improvements they have seen in their own patients, PE can be seen as an incredible tool for healing. One psychologist at the Trauma Clinic, Dr. Richardson, claims to have seen Vietnam vets who have had chronic PTSD for 30 years suddenly showing dramatic improvement after only twelve weeks of exposure therapy– able to go to the mall, able to go to a movie. He has heard from Vietnam vets in treatment, "'I was told that I might get a little better but I'd always have the disorder,'" he says, "and now they're in PE, doing therapy, and they're getting better." Another psychologist I spoke with, who has used these techniques among active duty soldiers in Iraq, said results were so powerful that he has seen soldiers return to duty with no remaining symptoms. Among clinicians who speak in support of exposure therapy, there can be a profound sense of relief that, after decades of mental health providers watching PTSD-diagnosed veterans fail to show significant improvement, sometimes despite years of psychodynamically-driven therapy, they now have a treatment with measurable benefits to offer their patients. Among the veterans in the PDS study, both Derek and Chris had already left PTSD treatment because their symptoms no longer met the criteria for a PTSD diagnosis. They both say that Dr. Richardson, using PE, has changed their lives.

Nor is exposure therapy a marginalized approach. In early 2008, the VA kicked off a "roll-out" of Prolonged Exposure (and also Cognitive Processing Therapy, which includes

elements of exposure work), holding workshops all over the country to teach VA providers how to utilize these strategies in their work with PTSD.[51] The goal is to make empirically-supported treatments nationally available to veterans, and to increase the level of standardization in VA mental healthcare. The San Antonio Trauma Clinic has been widely recognized as ahead of the curve in making evidence-supported treatments their standard of care; the Clinic's director has been asked to speak at regional conferences and provide mentorship for other VA Trauma clinics attempting to follow their lead.

Nonetheless, there are those who feel that prolonged exposure is at best unproven for use with combat PTSD, and at worst unethical, risking the re-traumatization of already vulnerable individuals.[52] Psychodynamically-inclined clinicians express a fear that the client may "decompensate," a notion suggesting that a variety of emotional reactions may result from engaging too directly with traumatic memory, ranging from a temporary loss of control to a complete psychotic break. This is a powerful concern – one clinician called the use of these therapies with recent veterans "unconscionable" – and not simply a local one. After giving a talk on the debate over PE at a national conference, I was approached by a psychoanalyst who shuddered dramatically as she described the risks of talking too directly about trauma. There is sincere trepidation behind this unease with PE, and yet this mistrust also plays into professional oppositions. At a training workshop on exposure therapies, the presiding clinical psychologist joked that (psychodynamic) 'counselors' may be wary of PE because 'they like to pet their

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[51] (Rauch, et al., 2009)

[52] Most of the research on PE (as of mid-2009) has been conducted on survivors of rape or other single, non-combat trauma events. Thus the concern that PE may prove less effective among survivors of the ongoing and cumulative trauma often associated with combat. One recent study, however, found that PE is an effective treatment among combat veterans, with effect sizes comparable to previous findings in veteran and non veteran populations (Rauch, et al., 2009).

patients rather than make them suffer sometimes.' Advocates and antagonists of exposure therapy typically come from different disciplinary and generational backgrounds: individuals supporting prolonged exposure therapy tend to be younger and trained in clinical psychology or psychiatry, while those with reservations tend to be older and have come from other mental health paradigms, such as social work, counseling psychology, marriage and family therapy, or psychoanalysis. There may be some amount of professional and material concern involved as well, for those expressing concern about exposure therapy are typically those who have not been trained to perform it, and vice versa.[53]

Even clinicians who support the use of PE, however, are mindful that it can require asking a great deal of patients. The same clinical psychologist who teased about 'making patients suffer' acknowledged this issue and said that she'll explain to new patients, 'Look, if you had a broken leg, the doctor might tell you that you need surgery to fix it properly so that you don't have a limp. Now, the surgery may make you more incapacitated for a while, until you heal from that, but ultimately it will make you healthier and stronger than you would be without it.' Interestingly, she also pointed out that many of the anxiety disorders are treated using therapies that can prompt an initial increase in anxiety, but said that she only ever hears complaints about this with regards to treatment for PTSD. She related this to a sort of morality of trauma, a mindset in which people think that trauma patients have already 'suffered enough'.

At base, psychodynamic and CBT perspectives spring from greatly different understandings of what remembering trauma does to the self, whether luring the *mind* close to

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[53] Although certainly this perception of trauma as something potentially dangerous – damaging not only to live through, but also to discuss too closely – is in certain ways in harmony with lay models of trauma in American society.

an emotional and potentially psychotic abyss, or pushing the *stress response* to pass through the normal processing of an event. Although both perspectives recognize the lasting effect that talking about trauma may have on an individual's cognitive and emotional register, the divergence between them was great enough to create friction during the Trauma Clinic's move toward an evidence-supported treatment (EST) model. This necessitated that the shift occur slowly, taking place over the course of several years. Therapists who were worried about letting go of their patients negotiated a gradual process of cutting back sessions – patients who had therapy once a week cut down to 2-3 times a month, then to a few times a year. Long-term veterans' groups (some of which had been ongoing for ten years or more) were gradually brought to a close or relocated to non-clinic facilities, like the local USO. The clinic's director brought in a well-known clinical psychologist to host a training workshop on ESTs in May of 2006, preceding the national roll-out by 18 months. As of the spring of 2008, the clinic had phased out all but two of its long-term groups, both of which were aimed at the clinic's oldest population of WWII and Korea veterans.

The new roster of services looks, on the surface, much like the old. Psychiatrists still offer medication management; psychologists and social workers still offer both individual and group therapy options. But there is an ideal pathway to the care now, a notion that patients should flow in to receive prompt care and out having regained the ability to function. Veterans who come in and receive a diagnosis of PTSD are brought into a six-session "psycheducation class" that deals with understanding and managing their illness (called PTSD 101), and then may pass into short-term groups dealing with specific concerns such as stress management or anger management. Individuals in severe distress may also receive individual therapy, either immediately upon entering the clinic or after having passed through the groups. The number of

Trauma Clinic staff members available to provide PE and other ESTs remains limited despite increases in VA funding in recent years, and so the clinicians have experimented with trying to reorient these therapies for use in a group setting, with mixed success. Several of the clinicians have worked to bring health outcomes research into the clinic, in an attempt to continually refine treatments and services. The structure morphs as the effort to adapt continues; different providers find themselves in charge of diagnostic interviews, clinicians' schedules change as the clinic initiates evening hours to serve working veterans, the pathway of referral changes a bit. In 18 months of observing the clinic, I found that little remained static for long.

Nonetheless, the larger shift has been in the VA's cultural paradigm for PTSD treatment, moving from a model focused on treating PTSD as a long-term disability to a model focused on time-limited treatment and the goal of recovery. Towards the end of fieldwork, one of the clinicians compared the new system favorably with the post-Vietnam era, when the treatment paradigms and services were not yet in place and veterans returning home with problems were left to self-medicate on their own. His manner warmed as he noted that his colleagues, armed with the new CBT treatments and an arsenal of pharmaceuticals to support them, were now getting to see patients get better. For a clinician, this is the Holy Grail.

As a VA employee, on the other hand, he understood that the idea of a 'recovery model' raises some potential for controversy. For the notion of recovery can be taken so far as to mean losing one's PTSD diagnosis, and if there is any one issue most likely to upset some visible minority of the frustrated veterans we first met in the audience of the Veterans' Forum, it is the idea of *not* having PTSD. How could this be? One word: compensation.

Who's Right/Whose Rights?

Issues around compensation for service-related disabilities invariably seem to invite controversy. The basic system of VA compensation works like this. Veterans are evaluated for health concerns upon leaving the military (which, just to make things confusing, has a disability evaluation and compensation system separate from the VA's) and upon entering the VA system. Health concerns are assessed across a series of appointments as Primary Care providers refer veterans to specialists for further evaluation. Once any physical and/or mental health conditions resulting from military service have been identified, a veteran may start the process of submitting a claim to the VA. Usually, this will initiate a second health evaluation (or series of evaluations, if there are several conditions under consideration) called a Compensation and Pension (C&P) exam, which provides independent confirmation of the original diagnosis. The medical records compiled from these evaluations are then submitted along with documentation of the veterans' service to the Veterans Benefits Administration – which, by the way, operates as a separate arm of the VA than the Veterans' Healthcare Administration, which oversees all VA hospitals and clinics.

If the Benefits Administration decides that the claim shows sufficient evidence that a health condition is real and service-related, the veteran will be awarded a disability rating of between 0-100%. A zero percent rating means that the veteran is eligible for free VA care for that condition. A rating of 10% or above means that the veteran is eligible for a monthly compensation payment, pro-rated according to the level of disability and the number of dependents a veteran can claim. Monthly compensation payments may range from $123 for a 10% disability awarded to a veteran with no dependent spouse, parents, or children, up to

$3000 for a veteran who is 100% disabled and has three or more dependents.[54] A single veteran may receive compensation for multiple conditions, but no matter how disabled the individual is determined to be by each condition, his total disability can never add up to more than 100%. Ratings can also be given out on a temporary or a permanent basis. Although PTSD compensation is often talked about in temporary terms – as something that can be taken away - I have yet to hear of a single instance, from a clinician or from a veteran, in which PTSD compensation payments were actually revoked. By 2004, total VA disability payments for PTSD were totaling $4.3 billion dollars annually.[55]

This is not an insignificant amount of money, which may help to explain why the group Veterans for Common Sense filed a lawsuit against the VA in 2007, accusing the VA of, among other things, "deliberately cheating some veterans by working with the Pentagon to misclassify PTSD claims as pre-existing personality disorders to avoid paying benefits."[56] The Executive Director of Veterans for Common Sense, Paul Sullivan, was quoted as saying that, "The VA has betrayed our veterans." The lawsuit demonstrated how the issue of diagnosis has at times become tied up with one of veterans' rights. The suing organization did not assume, as clinicians might, that clinicians were acting only in line with professional standards, nor that veterans might be accurately diagnosed with a personality disorder rather than with PTSD. In the mind of the veterans involved, individuals who *should* have been diagnosed with PTSD were being diagnosed with personality disorders instead, and this was being done with malice and

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[54] Figures based on Veterans Compensation Benefits Rates Tables as of December 2008, the most recent date for which information was available. Up to date information on benefits tables are available from the U.S. Department of Veterans' Affairs website at http://www.vba.va.gov/bln/21/Rates/comp01.htm.
[55] (Frueh, Grubaugh, Elhai, & Buckley, 2007; IOM, 2007)
[56] (Yen, 2007)

aforethought in an attempt to save the government money.[57] Held to be complicit in this effort, VA clinicians were seen as robbing veterans of their rightful benefits, their (mis?)diagnosis constituting a betrayal.

In truth, the issue of diagnosis, when viewed alongside concerns over compensation and veterans' rights, becomes clear as mud. From a professional perspective, clinicians view diagnosis as an act of discernment and expertise. The DSM sets out a list of symptoms which, in their presence and severity, indicate whether someone does or does not meet the criteria for a diagnosis of PTSD. Yet making a diagnosis is not a simple task. Clinicians at the Trauma Clinic talk in great detail about the lengths they go to in the effort to ensure that a diagnosis is appropriate, using nationally accepted assessment measures, a process of weeding out other possible diagnoses (what is called a process of "rule-out"), and of determining whether PTSD may co-exist alongside one or more other disorders. Such comorbidity is common. Among PTSD-diagnosed veterans in this study alone, comorbid diagnoses included substance abuse, depression, panic disorder, bipolar depression, and schizophrenia, and several veterans had gone through multiple examinations in order to ensure that their diagnoses were correct. Clinicians described this testing process as both professionally necessary and ethically responsible, pointing out that an individual given an inappropriate diagnosis is unlikely to receive effective treatment.

Given public debate over whether the VA is adequately responsive to veterans' needs, however, such careful assessments can also be seen in profoundly negative terms. A diagnosis of personality disorder, legitimate and laudable within the world of professional psychology,

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[57] This bears similarity to Briggs' (2004) analysis of explanations of a cholera epidemic, and the role of political economy in shaping public discourses.

may be read from another perspective as part of a conspiracy to deprive veterans of due disability.[58] And so a diagnosis within the VA system is not just a matter of putting the right name to the right illness. It is an act of determining who gets access to what kinds of care and what kinds of resources, and can at times seem to occur under a public spotlight.

This was made very clear in the Spring of 2008, when Norma Perez, a VA psychologist in Temple, Texas, sent an email around to the rest of her staff. The text of the email, which was promptly leaked to the veterans' group VoteVets.org and became the center of yet another VA scandal, included the following:

> Given that we are having more and more compensation-seeking veterans, I'd like to suggest that you refrain from giving a diagnosis of PTSD straight out. Consider a diagnosis of Adjustment Disorder, R/O [rule out] PTSD.
>
> Additionally, we really don't or have time [sic] to do the extensive testing that should be done to determine PTSD.

Norma Perez's email left much unsaid, which is perhaps a part of what left her so vulnerable to public censure in the weeks and months after her email was made public. She wrote in clinical language, the language of her profession. When she wrote "compensation-seeking veterans", she did not clarify whether she thought these veterans were seeking compensation rightfully or fraudulently, although the fact that she was worried about giving out PTSD diagnoses would suggest that she was not convinced all compensation-seeking veterans had PTSD. She advised that clinicians offer a less severe diagnosis of "Adjustment Disorder," but also that they do so in a temporary fashion, pending a more thorough rule-out of PTSD, which requires "extensive testing" for which they did not have the time. There is the echo of a

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[58] (Briggs, 2004)

clinician's concerns here: appropriate diagnosis given after due testing, and the pressure of providing care for veterans in an atmosphere of limited time and manpower.

Yet her email was read by some veterans' organizations as evidence of a larger VA effort to deny veterans of their rightful compensation. A member of the nonprofit organization Citizens for Responsibility and Ethics in Washington, which released the email jointly with VoteVets.org, was quoted as saying that, "It is outrageous that the VA is calling on its employees to deliberately misdiagnose returning veterans in an effort to cut costs. Those who have risked their lives serving our country deserve far better."[59] These accusations were considered politically viable enough to warrant a vehement public denial from the Secretary of the VA, James Peake, and to prompt a Congressional hearing at which Norma Perez was called upon to explain and repudiate her remarks.

The Perez case is only one example of the way in which VA clinicians may be called upon to function within a wider political realm; they are asked to act in accordance with their own professional expertise while simultaneously serving as the face of a government controversy that both precedes and transcends them. They do not only provide care; they must also perform it.

Accordingly, a shift in treatment paradigms at the San Antonio Trauma Clinic does not represent simply an evolution of clinical knowledge, but also a political move with potentially explosive consequences. What would happen, for example, if (and I emphasize the *if*) the exposure therapies proved to be effective on a grand scale, so that Trauma Clinic staff were able to help many veterans with PTSD to get better and transition out of continuous care? Such an

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[59] (Lee, 2008)

outcome could provide astonishing hope that future generations of veterans will suffer less than did the Vietnam generation. But it might also present a circumstance like this one, in which a veteran who has previously been diagnosed with PTSD walks into the San Antonio VA's C&P Office and says to the clerk filing his PTSD claim, 'I don't know. I went through Dr. Richardson's program and I just don't really have it anymore.' Which is the story that one C&P officer told Dr. Richardson.

Such a story begs the question: Will a revolution in PTSD treatment – if it proves to be successful in helping OEF/OIF veterans to recover from PTSD – require a revolution in the compensation system? And if so, what then?

Clinicians interviewed in the study were sensitive to issues of compensation, although some also expressed sensitivity to the political ramifications of saying so on the record. They were aware that some veterans may come to them with a desire for disability pay more compelling than their PTSD symptoms. There is discomforting evidence to show that this is the case. One recent study found, upon reviewing the medical records of veterans with PTSD, that, "Most veterans' self-reported symptoms of PTSD become worse over time until they reach 100% disability, at which point an 82% decline in use of VA mental health services occurs…."[60] So either some veterans are exaggerating symptoms until they achieve the highest possible level of compensation or they are just giving up on VA care (which is a real possibility; it is only recently that the possibility of treatment to recovery has begun to be bandied about). Of note: the same study found no such change in veterans' corresponding use of medical health services. Although none of the veterans in the PDS study admitted to flat-out faking symptoms, a handful

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[60] (Frueh, et al., 2007)

did say that they were only seeking treatment in hopes of supporting their compensation claims.[61] Clinicians are fully aware that some minority of veterans comes to them seeking compensation more than healing, although this was not a concern on which they seemed to spend a lot of energy. One psychiatrist told me, 'I err in [the veterans'] favor,' adding, 'I'm here to serve them. I'm not a detective.'

Still, beyond the more obvious question of sincere distress vs. exaggerated or wholly manufactured distress, several staff members raised subtler concerns about the impact of compensation on veterans' lives, for better and for worse. Several mentioned their concern for older veterans with PTSD, many of whom may have been on disability for decades, and who they fear would be left broke and unemployable if their compensation were revoked. Others speculated that perhaps lifelong compensation was not the best thing for veterans with PTSD, that perhaps the perpetual promise of a monthly payment inhibited them from seeking out employment and making career choices they might find fulfilling and empowering. Perhaps the identity of a disabled veteran was a poor exchange for the quality of life of someone who saw himself as recovered and well.

Clinicians are ethically bound to practice in accordance with professional standards, but there must be moments when a checklist of symptoms seems a poor guide through the quagmire of a PTSD diagnosis.

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[61] That said, I also didn't ask, either directly or indirectly.

Caring For Him Who Has Borne the Battle

Like the U.S. military, the VA represents an American institution that is responsive to political pressures while being simultaneously driven by its own political economy of resources and obligations. The VA contemporary with the wars in Iraq and Afghanistan has been beset by scandal and forced into the position of having to provide care for a new generation of young men and women with unanticipated healthcare needs. At the same time, the VA continues to bear much of the burden of public shame over how veterans were treated in the wake of the Vietnam conflict, thus reinforcing its contractual and symbolic obligation to "care for the troops". Both contemporary necessity and historical legacy have led the VA to function as an institution on the defensive over the past several years, and individual clinicians within the VA, like Norma Perez, have at times found themselves on the front lines in the ongoing conflict over veterans' healthcare and veterans' rights.

At the same time, mental health clinicians in the San Antonio VA's Trauma Clinic have been hard at work on a revolution of their own, reimagining patterns of PTSD treatment in line with an evidence-supported CBT model at odds with the standard of care among an older generation of psychodynamic clinicians. The evolution of providers' knowledge and practice continues to shape mental healthcare within VA Clinics both locally and nationally, with extraordinary – although yet untested – potential for changing the way that the majority of veterans experience PTSD.

Although fascinating if only for its impact on treatment and care-seeking, the shift to a 'recovery model' of PTSD treatment also urges the question, is it possible that PTSD could come to be viewed as a short-term or recurrent illness rather than a chronically disabling disorder? As PE and like therapies become the gold standard of care in the VA, the coming years should begin

to provide an answer. If the recovery model proves viable, it will not only radically redefine current expectations for PTSD as a lifelong disorder, never shed once acquired, but will also demand a dramatic reconsideration of the existing system for PTSD-related compensation, which will likely, in turn, prompt an intense political battle over America's financial obligations to its veterans. If, on the other hand, the new emphasis on evidence-based treatments fails to produce a marked change in the quality of life for veterans with PTSD, the results may look all too familiar. We may see decline among this generation's PTSD-diagnosed veterans, those who slip through the cracks and live as enduring reminders of the psychological cost of war.

Although the outcome of this current uncertainty will have far-reaching consequences for national policy and many thousands of lives over the coming generation, it is a drama that will be largely played out – once again – on the intimate level of human relations, in the space between PTSD-diagnosed veterans and the clinicians who treat them. This is the subject I turn to in the next chapter.

Center of the Storm

The Clinic, Part II: Therapeutic Interactions

Chapter Seven

One afternoon when I was interviewing one of the psychiatrists at the Trauma Clinic, a patient in the next office began shouting furiously at his clinician. The sudden disturbance prompted a hush in the surrounding clinic, as those within hearing waited to see whether the conflict would escalate. It was quickly over; the man calmed down and the appointment continued. Strangely enough, when the clinician who was the object of the man's frustration later told me about the event, he did so in the process of describing how warm and appreciative he finds his PTSD patients. He said that for all that the veterans he treats may have issues with anger, and for all that they may at times be frustrated by their experience of the VA as an institution, they are pretty good at what he called 'splitting.' They may complain that the VA asks them to go to too many appointments, or takes too long to schedule referrals, or fails to resolve their compensation claims, but they tell him, 'I know that's not your fault, Doc.'

The clinician seemed to be suggesting that, despite the politicized backdrop of opposition and distrust, veterans and clinicians at the VA Trauma Clinic manage for the most

part to create a separate peace, if occasionally a wary one.[1] This was consistent with what I heard from veterans, and what I witnessed, too, in interactions between veterans and their care providers. Although PTSD diagnosis, treatment, and compensation remain hotly contested in and around the VA, these debates often remain behind the scenes in everyday clinic interactions, interactions which themselves play a profoundly important role in shaping many veterans' experiences with PTSD. Families and military personnel can and do offer up a wide array of powerful messages about PTSD, but mental health clinicians are the understood experts and their views carry great weight. Distressed veterans who come to the Trauma Clinic in search of help have much incentive to listen to their clinicians, and clinicians, as individuals who have chosen a healing profession, describe a deep commitment to providing the best possible care for their veteran patients.[2] This chapter examines these interactions more closely, and finds in them an array of possibilities – trust, mistrust, resistance, negotiation, and change.

Confronting Exposure Therapy

Of course, PDS study veterans were not blandly accepting of VA clinicians' expertise on the subject of PTSD; on the contrary, it was not unusual to find them expressing partial or complete objection to a clinician's viewpoint or treatment suggestion. For example, at a certain point I began running into PTSD-diagnosed veterans and clients of the Trauma Clinic who expressed serious reservations about exposure therapy, although many had never tried it.

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[1] There are rare exceptions to this. Shots were fired one night in 2007 through a window at the San Antonio VA, although the culprit was never identified. There are very occasional threats made against the VA or particular VA employees, although this is not unusual in mental health care.

[2] Clinicians may themselves be veterans, or the sons and daughters of veterans, and often expressed satisfaction at being able to provide care for those they valued as having served their country.

This first occurred in the context of a group therapy session I observed. Two of the Trauma Clinic psychologists were conducting a modified form of exposure therapy in a group format, attempting to provide immediate treatment for a sudden flood of OEF/OIF veterans. One of the participants, a former Marine who had lost his hand in Iraq, spoke up to ask, 'Why do we have to think about these things that happened in the past? Why, to deal with PTSD, do we have to remember all this stuff?' Upon receiving the answer to his question – namely, that it is necessary to process these memories in order to reduce the anxiety they create – he nodded, but said, movingly, 'Because it's hard, thinking about these things.'

The Marine was not the only veteran who was hesitant to delve so deeply (which proponents of exposure therapy would likely point to as an example of continuing avoidance). In later interviews and group observations I conducted, the issue of 'having to talk about these things' came up regularly, with individuals expressing a range of responses to the idea of probing so intently into what seemed to be dangerous memories, whether in group or individual therapy settings. Some, like Chris, began by being hesitant about the idea only to become more comfortable as the treatment went forward. He says, "When Dr. Richardson [first] told me about it, I was like, 'I'm outta here.' I thought we were going to shoot fireworks or go to a gun range. I didn't know what exposure therapy meant." Even when Dr. Richardson explained to him what the therapy would entail, he remained skeptical. "'Fuck that,'" he said, "'There's no way.'"

Chris says that, if you listen to the audiotapes made in his individual sessions, you can hear that he starts off "with a real edge. Dr. Richardson's coaxing things out of me. And I'm talking about really minor stuff – things that aren't even traumatic, but that I was having nightmares about. Then into this phase that was very emotional, where I'd be sobbing for 15-20

minutes. Then into this phase where I'm talking about the most gruesome awful things, and I can remember every detail – what I was wearing, the smell, everything such clear – diarrhea of the mouth, just vomiting into the tape. It got easier. I never thought I'd be able to talk about that stuff. Talking about it now I start to sweat. Not that I'm freaking out here – just these are very intense things."

On the whole, he says, "It was very difficult and then it got very easy. Three, four months. We started out with the easiest – 'Tell me about getting shot at.' Some things took 15-20 minutes. Others took A&B sides, two tapes. Each week I would go from one to the next, and I would think about them, talk about it, listen to it for a few days, and then start thinking about the one for [my appointment] next Friday, so I could talk about it the very next Friday. So it went real slow at first, then I got good at being able to bring these things up and stop repressing them."

Some veterans, in other words, found their initial resistance to exposure therapy was resolved over time, often with some "coaxing" from their providers.[3] Others (like Adam, whose experience with treatment is described in Chapter Nine) refused outright to do exposure work; a few found the idea so intolerable they left VA care altogether and sought treatment in the private sector. One veteran calculated that he had spent something like $10,000 on private counseling in the previous two years. Another (who was studying for his master's degree in social work) told me that he "disagreed" with exposure therapy and would not continue treatment, although he was uninterested in elaborating on why. From a clinical perspective, this kind of resistance can be a matter for concern, given that the primary OEF/OIF clinicians – the

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[3] One would imagine this is to some degree an outcome of burgeoning trust in that relationship (e.g. Battaglia, Finley, & Liebschutz, 2003).

default providers with whom OEF/OIF veterans come into contact – are strong advocates of exposure therapy. Treatment compliance and drop-out is a regular problem among OEF/OIF veterans seeking care at the Trauma Clinic.[4]

The resistance of some veterans against exposure therapy is interesting, too, in light of the fact that tensions at the clinic over the shift towards evidence-supported therapies did at times become visible to patients. Several psychodynamic clinicians I interviewed reported discussing their concerns about exposure therapy with patients. A handful of the newer providers reported hearing from veterans that they had postponed seeking care at the VA because a former VA clinician – who now maintains a private practice, working primarily with Vietnam veterans – had spoken negatively about exposure therapy to their Vietnam-era fathers. One veteran reported that this clinician, Dr. Orion, had said that exposure therapy was experimental and that veterans were being used as guinea pigs; another reported something similar on the last session before he stopped coming to therapy at the Trauma Clinic. And so conflicts that began between clinicians had the potential to leak out into encounters with veterans, affecting how they viewed particularly therapies and, ultimately, their willingness to engage in them.

Given the distrust of civilians expressed by some veterans, it may be that clinicians who are not veterans themselves, as most of the providers at the Trauma Clinic are not, are

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[4] There appear to be a number of reasons for treatment drop-out among OEF/OIF veterans, which is a phenomenon that clinicians I spoke with at a recent national VA conference said that were seeing all over the country. These veterans tend to be young and are often involved in the early stages (and heady obligations) of their family, educational, and career lives. Several of the clinicians polled veterans about their reasons for treatment drop-out, and veterans reported feeling like they didn't have enough time to attend sessions and/or had scheduling conflicts. Regardless, there does appear to be a significant contrast between continuance rates among Vietnam era veterans and their OEF-OIF counterparts.

especially likely to encounter clients who respond to treatment suggestions with some suspicion. During one group session at the Trauma Clinic, an unknown veteran walked uninvited into the room and stood at the back, loudly challenging the clinicians to tell him whether they had ever been in combat and, when they said they had not, yelling that they 'didn't know shit'.[5] The implication was that they had no business teaching veterans how to deal with combat if they had never encountered it themselves.

Challenges to the Trauma Clinic's new reliance on evidence-supported treatments, then, fell not only into the realm of veterans' existing distrust of the VA, but also into the realm of professional conflicts over who knows best how to treat what and clinicians' claims to know what treatments are best for veterans. Both of these debates can be seen to reflect concerns over "authoritative knowledge," that question of whose knowledge holds most authority when a conflict arises.[6] Where trust is lacking – as may be the case in any healthcare setting, and particularly so in a setting as politicized as the VA– the question of who knows the "truth" about best practices in PTSD treatment is liable to take on an added level of conflict, with very real potential to influence how veterans make decisions in their pursuit of mental health care.

Psychoeducation Groups

Despite these challenges, clinicians were in many cases a key influence on how study veterans understood their PTSD – providing new perspectives on PTSD illness, symptoms, and strategies for coping. Given the pressure on clinic resources, much of the interaction between

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[5] This event was described to me by both of the clinicians involved and two of the veterans who had been attending the session. One of the clinicians opined that the disruption, perhaps ironically, seemed to strengthen the group's rapport rather than weakening it.

[6] (B. Jordan, 1996)

veterans and clinicians plays out in the context of the short-term psychoeducation groups offered at the Trauma Clinic. These groups are often referred to as 'classes,' and do serve an educational function, providing veterans with expert perspectives on the symptoms and causes of PTSD and on ways to manage symptoms and related life problems. The classes also aim to help reduce PTSD-related anxiety, the thinking being that if veterans know to expect certain symptoms and can make sense of them within a larger framework, they will find them less distressing. Because these groups can be a powerful force for shaping how veterans think about and live with post-deployment stress, the remainder of this chapter provides an ethnographic look into the lessons and social interactions they provide.

A variety of groups are offered at the Trauma Clinic, each varying in line with its intended purpose. I attended group sessions for two months during the Spring of 2007,[7] and during that time was able to visit: two unstructured supportive therapy groups for WWII and Korea veterans; a PTSD 101 psycheducation group for Vietnam and Korea veterans; a PTSD 101 group for OEF/OIF veterans; another group that was being combined with individual sessions in an effort at expanding exposure therapy for use in group format; and a support meeting for combat spouses (who were, at that time, all spouses of PTSD-diagnosed veterans of Korea or Vietnam).[8] The groups themselves represented a rough split between the clinic's older and newer treatment paradigms. The WWII/Korea and combat spouses group had both been

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[7] This attendance was approved as part of the original study protocol, under the provision that any observations based upon these groups be presented in such a way that no one in attendance could be identified. I have, therefore, taken particular care to disguise the identity of these individuals. I was always introduced as an anthropologist and researcher studying the effect of PTSD on veterans and their families.

[8] I attended the WWII/Korea groups on one occasion each, and all of the other groups on between two and five occasions. I also conducted participant recruitment in a dozen or so additional groups over the remaining year of the study, although these visits were brief and I left as soon as I had made the announcement.

ongoing for some years, and both were run by social workers who largely let the conversation move ahead without intervention. The PTSD 101 and PE groups, by contrast, were run by clinical psychologists, time-limited, and highly structured in line with Cognitive Behavioral Therapy (CBT) and exposure therapy principles.

Each of the veterans' groups presented an opportunity for veterans to engage with clinicians and other veterans in an effort to manage their post-deployment distress. It is important to note that, by the time veterans in the study found themselves sitting in a group room at the VA, most had come to accept that their readjustment challenges were a result of PTSD (I will discuss the process of coming to accept this diagnosis more fully in Chapter Nine). At the same time, many veterans admitted in study interviews that they had been initially wary of 'group therapy,' which seemed to carry unsavory connotations of appeasement – as if it were somehow less than *real* (individual) therapy, and were being offered as a poor substitute.[9] Veterans also expressed concerns about privacy and the fear of having to discuss problems and traumas in a group setting.

Those who attended the groups, however, often found there was a great deal of information on display. During the first session of a PTSD 101 group for OEF/OIF veterans, the three presiding clinicians – a clinical psychologist, a social worker, and a psychology intern – began by introducing themselves and outlining some basic information about the class for the eight veterans in attendance. The meeting was held in a large auditorium in the main VA hospital, as an earlier class held in a very small room had made the veterans feel crowded and uncomfortable; it was thought that the larger room, with its low lights, open space, and walls

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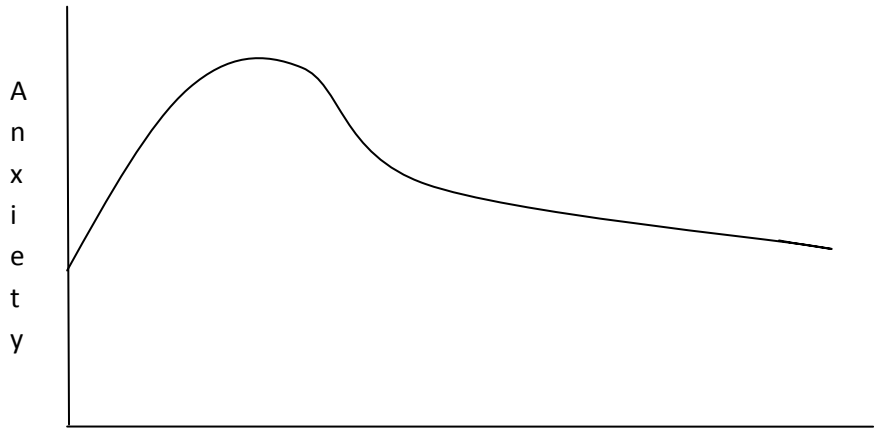
[9] In part, this seemed to reflect a concern about privacy and having to discuss one's problems and traumas in a group setting.

decorated with old cowboy movie posters, might be more welcoming. The presiding psychologist, Dr. Richardson, explained that he had been brought to the VA earlier that year to start a program specifically for OEF/OIF veterans with PTSD, utilizing new treatments to bring the best possible care to returning veterans. He then asked the veterans to introduce themselves, addressing each in turn as Mr. _____, following standard VA etiquette. The social worker read through a list of rules for the group – no violence, speak respectfully to one another, avoid talking about particular traumatic events, and always do the homework – and then the psychologist stood up to make a list of the three PTSD symptom clusters: Re-experiencing, Avoidance, and Hyperarousal. He explained each of these, listed off a few examples of key symptoms, and prompted the group to talk a little bit about their own experiences with each.

He asked the men (for all of the veterans in this group were men, although I regularly saw at least a few women in each of the OEF/OIF groups) to talk about what anxiety is. One man, a young Latino from San Antonio, offered that anxiety is a feeling that tells you something is wrong, and volunteered that he knew something about PTSD because he had done a report on it for school. The psychologist asked, 'Did you relate to those symptoms? Did they make sense to you?' 'Yeah,' the young man answered. An African-American veteran sitting a few seats over chimed in to add that he had been a medic and had given classes on PTSD, but still had not associated the symptoms with his own experience until he was back home. He said, 'You just teach the classes and then forget. You just keep going with everything else until there's time to think and you realize what's going on.'

Dr. Richardson acknowledged this, and then returned to the issue of anxiety, drawing a rough diagram on the board, something like this:



He then asked the group what causes them anxiety, and one veteran volunteered 'going to Walmart.' Dr. Richardson then said, 'Ok, so you go to Walmart and it makes you anxious, so you *leave*. But if you leave then, you never learn that the anxiety will steadily diminish as you learn that there's no real threat. If you'd stay, you'd keep walking around the store and realize that nothing bad is going to happen. This is how avoidance and arousal are related. If you start avoiding things and you feel better, you start thinking that your arousal is ok, that there *must* have been a threat because you felt better when you left. If you never give it a chance to realize that there's no threat, you'll never get to the point where the anxiety goes away.' He stepped back from the drawing for a moment to ask, 'How many of you guys were afraid to come in because you thought it was weak to have PTSD?' There were a few quiet murmurs from the men before he spoke again, asking rhetorically, 'How can it be weak if this is a natural process?'

There was a pause, and then Dr. Richardson continued on to say that human beings, like all animals, can acclimate to any situation if nothing frightening happens. He gave an example he had heard from one patient, who talked about feeding mice to his pet snake. If the snake

wasn't hungry, the veteran had found, the mouse would start out by running in terrified circles around the cage, but would ultimately calm down as the snake just lay there. That's how anxiety works, he said. The mouse can't stay at such a high level of arousal indefinitely. (He added here that, unfortunately for the mice, they eventually get eaten anyway.)

The importance of pushing through periods of anxiety until the discomfort lessened was a theme that was reiterated several times, and the intern, a young woman named Jessica, spoke up once to say, 'Sometimes veterans tell me that they come to these groups and feel worse when they leave, but that's ok. That's to be expected. That's because you're doing some work here.' Dr. Richardson added, 'And that will get better as time goes by and you realize that this is helping.'

Dr. Richardson then returned to a more general discussion of the group's purpose, and encouraged the men to 'bring your girlfriends, spouses, family – getting them involved can be a real asset.' (At least one of the men had already taken this advice: the young Latino was accompanied by his girlfriend.) He went on to say that, 'Psychiatry and psychology are relatively new fields, as opposed to chemistry, physics, mathematics, etc., and that means that you are an important generation. It's your job to help us educate the public about PTSD, so talk to people about it, your family, your friends, other veterans, so we can all be more educated about what this is.'

Some more general conversation followed, and at one point, one of the men started to say, 'I got hit by an IED,' which prompted Dr. Richardson to remind him not to talk about the details of their own traumas in the group. He explained that this was intended both to avoid making other people feel bad about the relative size of their own trauma (for example, 'I didn't

get hurt but he lost his leg,') and to avoid veterans comparing stories and trying to one-up each other. The veteran went on to continue his story, but left out the details of the explosion itself.

At the end of the session, the clinicians spoke for a few minutes about what to expect throughout the remainder of the 8 week class, which was to include sessions on cognitive therapy, relaxation techniques, assertiveness training, strategies for dealing with family members, and so forth. Dr. Richardson said that, 'We are all part of this treatment team. I want you to get to know one another, exchange phone numbers. Call each other and talk if you want to. You are a great resource for one another.'

In the course of a single session, then, the clinicians running the group began a process of teaching PTSD-diagnosed veterans a series of lessons about their illness. First, they offered a new way of seeing PTSD and PTSD symptoms: as an anxiety disorder that emerges very naturally out of the mammalian stress response (mice do it, too!). They suggested a wholly different perspective on PTSD than I found among family members, in the media, or even within the military's focus on normalization and readjustment (although readjustment similarly identifies post-deployment struggles in relation to the survival skills learned in a combat zone). In the group therapy setting, VA clinicians offered a model of PTSD that was neither a sign of weakness nor a victimization, but was instead centered around a series of emotional and behavioral symptoms driven by the physiological stress response.[10] Located this way in the involuntary

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[10] To return for a moment to the shift in PTSD treatment at the Trauma Clinic, we can draw some comparisons between the group described above and a group described by one of the more psychodynamically-inclined clinicians, an older man with a long white ponytail. He described his own group, which had been ongoing for many years and which he had moved out of the Trauma Clinic when the changes began in order to keep it continuing, as an "old-style kind of process group." I asked him what his group looked like in practice.

"Well, you work with the relationships that the people develop. You foster their relationships. You foster the bonding that occurs. You look at – you work with the way that they feel about each other.

structures of body and cognition, PTSD was presented as unavoidable and uncontrollable, something for which no veteran could be held responsible and no blame could be attached.

Even more importantly, in outlining a perspective on how this stress response works, these symptoms were presented as being *capable of transformation*. Jessica and Dr. Richardson promised the veterans reduced distress if they would just remain willing to re-evaluate their own cognitive, bodily, and emotional responses to the world. The clinicians argued that these responses – rewired by life in a combat zone, programmed to react to stimuli as signifying potential threat – were poorly matched to the realities of life in San Antonio, with its traffic and shopping and routines of contemporary America. In exchange for veterans' willingness to re-examine their interaction with the world around them, the clinicians offered the promise that Wal-Mart, once only a place to do some low-cost shopping, could return to being just that.

There were other lessons as well. The clinicians were bringing together veterans and encouraging them to talk to one another about their experiences ('we're all part of the treatment team'), but within specified boundaries (avoid talking about the details of the trauma). Veterans were offered the opportunity to see themselves as educators bringing a better understanding of PTSD to the community around them. 'It's your job to help us educate

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You think in terms of the group process, you think about what the whole group is trying to do and you follow that process rather than create it. You don't have an agenda. You start out wherever they are, and just facilitate to help it along in whatever the group of people are wanting to do that day. So if an opportunity comes up to do some kind of – to talk on a topic you might do it, but you only do that when the group seems ready for it." His model of a group, then, was similar to the PTSD 101 group in its focus on fostering relationships and encouraging bonding between veterans, but very different in its expectations for the role of the clinician. He saw his job as to foster processes that were already taking place, to speak on topics raised by the veterans themselves. His role – and this resonated with similar descriptions I heard from other psychodynamic clinicians, both psychologists and social workers – was to listen, to acknowledge hurt and suffering, and to help create a space in which healing could take place. In contrast, the new model of care, with its focus on ESTs, required a more active role for clinicians.

the public about PTSD.' They were offered the chance to speak as advocates on behalf of themselves and of other veterans.

In the groups that I was able to follow across a number of sessions, it was possible to see how some veterans took up these offerings and incorporated them into their own way of thinking and acting. For example, in the exposure group for OEF/OIF veterans that was run by Dr. Richardson and another psychologist, Dr. Lyndon, they began one session with a continuation of the same lesson on avoidance that Dr. Richardson gave in the PTSD 101 group above. Dr. Lyndon underscored the point that continuing to practice avoidance prevents the opportunity to reassess and update the threat level posed by a situation (going to Walmart, driving in San Antonio, etc.). He drew a picture on a large pad of paper to illustrate this, animating a stick figure about to flee from a suspected bomb.

One of the veterans in this group – which was held in a small conference room, giving the assembly of five veterans and two clinicians a more intimate feel that had the auditorium setting – spoke up to say that, for all the talk about avoiding and fleeing, he never felt the urge to flee. His problem, he said, was that he always wants to meet every potential threat head-on, whether in the interest of defending his comrades or his family. He wants to *fight*. The two clinicians stepped in to answer his question, taking turns to explain that both withdrawal and anger provide a means of avoiding a sense of vulnerability, and that both reactions represent the response to a false alarm (a false threat in the environment). The trick, they said, is coming to recognize the alarm as a false one.

Veterans in the exposure group drew upon this lesson continually as the weeks progressed, attempting to incorporate this way of thinking into their way of acting in the world. Drs. Richardson and Lyndon led the men through a series of exercises aimed at helping to sort

through triggering events and to determine whether the responses behind them – often called "automatic thoughts" – were appropriate or whether they represented what Cognitive Behavioral Therapy (CBT) calls "cognitive distortions". The men learned to examine their immediate bodily and emotional responses to events – rage, rapidly beating heart, fear, etc. – and to examine the thoughts that prompted such powerful responses. If the thought was a realistic one, it was accepted as recognition of a genuine threat. If not, it was recognized as a distortion and a more accurate triad of thought, response, and action was suggested as an alternative.

For example, during one of these sessions, one of the men – an exuberant guy they all called Bouncer - began describing how he had overreacted to an incident the day before. 'Yesterday I was about ready to kill somebody,' he began, then went on to tell the story. 'I was mowing the lawn, and my four-year-old daughter was out there with me, and this old guy came riding by on his bike. He stops his bike, and starts talking to my four-year-old, saying 'What a pretty little girl you are.' And my first thought was, 'I'm going to fuck you up.'' He said he slowed down and calmly walked the little girl inside, but described how enraged he had been, how ready to hurt the man, and how he had tried to calm himself down.

Dr. Richardson began to move through the usual exercise, asking the men to suggest how this response might have resulted from a distorted assessment of the situation. Bouncer admitted that he had automatically assumed the man was a rapist because he sensed potential threat, and had, emotionally, gone immediately into attack mode (even though he did not act on the feeling). 'You see red first and then you see gray later,' he said. One of the other men, Ernesto, suggested that he had assumed the old guy wanted to hurt his daughter, when maybe he just wanted to talk to her. He acknowledged the social niceties of approaching young

children. 'I have three kids,' he said, 'and when I go out alone, if I want to give a compliment to a child, I think about it first, what I'm going to say. Because if I go out with my family, people know I'm okay, but if I'm alone…'

There was general nodding around the room, and Bouncer, beginning to look relieved that the others understood, said, 'Yeah, because when he tickled her belly…' At that, the room erupted. The men spoke over one another - 'He did *what*?!' 'He touched her!' 'You don't go *near* my kids.' Bouncer gave more information – the man had gone up to his little girl and tickled her on the belly and said how pretty she was. He was an old man, though, without any teeth, and had seemed a little slow, as though he were mentally handicapped. Hence Bouncer's uncertainty about how to understand the encounter. The group spent a few minutes discussing the relative merits of the man as a threat, and then moved on.

What was so interesting about this story was how Bouncer's thinking about it was clearly influenced by the conversations the group had been having over the previous weeks. His internal response was as furious as ever (he had a history of bar fights behind him), but he stopped to think before he acted, questioning the nature of the presumed threat, and so had reacted less violently than he might have previously. In presenting the story back to the group, he expressed willingness to examine his own reaction for evidence of cognitive distortion and the other veterans in the group supported him in this effort. Perhaps, as Ernesto suggested, Bouncer *was* making a wrong assumption about the old man's motives.

Still, when the key detail of the story came out – that the man had touched his little girl – the other men went ballistic. The event had already been reframed once by Bouncer's narrative of it in relation to the lessons he was learning in the group. But after the tickling came out, the event was reframed yet again, and Bouncer's initial reaction of rage at a potential

threat was reaffirmed by the other veterans (a move left unquestioned by the psychologists). Moreover, each understanding of the story was accompanied by a different view of what emotions and behaviors counted as an appropriate response. Adopting the CBT model did not create a simple new template for these veterans in their efforts to renegotiate a sense of threat and safety in the world around them. It provided guidelines, but left room for context-based interpretation of specific events. Like all skills training, it was a learning process.

And yet for all its challenges, group therapy proved to be capable of exerting a powerful influence on how these men understood their symptoms (anger, avoidance), understood the world around them (is the old man a threat?), understood their own responses and behaviors (I am reacting aggressively *because* I am afraid he will hurt my daughter), and decided upon appropriate action (take the little girl inside). Bouncer was willing to reexamine his own responses in light of the new model, and the other veterans supported him in this process.

This was never clearer than the day when Ernesto, who was a respected presence in the group, came in and said that a young woman and her mother, both wearing Islamic headscarves, had come up behind him while he waited in line at a local restaurant with his wife. 'Now,' he said, 'what I would usually do is to step back out of the line, so that I could keep them in the side of my vision without looking directly at them. But this time I didn't. I purposely turned my back to see how it felt. I went back to talking to my wife. I was thinking, 'this is avoidance.'' Naming his wariness as a move towards avoidance, he chose to act differently this time, returning to face his wife and continuing their conversation. Turning his back created anxiety, yes, but he found it to be manageable, and he was not attacked from behind. This was no small thing. By the time he returned back to the group the next week, his recognition of the possibilities for his own actions and reactions had subtly changed.

And it was not only the present that was available for reassessment in the group setting. As the group proceeded, the men were asked to write detailed accounts of their most troubling traumatic memories. They were then asked to read these accounts repeatedly over the course of the week between group sessions, and to track the level of their anxiety as they did so, the idea being that the anxiety associated with each event would lessen as they repeatedly engaged with and processed it. (There was a very specific protocol given for doing this; I do not have space to describe this protocol here, but suffice to say, the men followed strict guidelines for how to go about the exercise, and began with memories that caused relatively little anxiety before progressing to those associated with more significant distress.) In this way, their memories – their war stories – became open to new understandings as well, using the CBT frameworks of both prolonged exposure and of recognizing cognitive distortions.

This was an exercise that the men sometimes struggled with, because of the time it required amidst their already busy lives (most had jobs and families), and because they sometimes found the exercise upsetting. When they followed through with the protocol, however, they generally came back to the group reporting that, yes, the anxiety associated with a given story had lessened. Dr. Richardson explained one day that, 'We want it to be so that you can pull out that memory when you want to, but it's not going to be coming back to you when you don't want it.' The men reported that the memories remained disturbing, but became manageable. Ernesto, for example, described a memory of a successful mission involving 'collateral damage' that for years had bothered him greatly; he said that, after the exposure writing exercise, he had found that the anxiety associated with the memory had dropped considerably, although it remained 'bittersweet'.

As with current events, there were times, too, when these war stories were subject to group examination, becoming ground for group support and sharing. Luke came in one day upset about events going on at home, and admitted that he had been unable to get through his writing for the week because he had been so distracted by the family crisis. He began talking about the combat experience he had been trying to write out, although carefully, mindful of the need to avoid too much detail. Dr. Lyndon asked whether he would be willing to use the memory as the focus for an exercise in recognizing cognitive distortions, to which Luke agreed, somewhat hesitantly.

He began telling his story, 'Well, I sent this soldier out into a situation that, if I had gone instead…' Immediately, Dr. Richardson stopped him, writing on a large pad of paper, 'sent out soldier – wounded'. He asked Luke to identify his emotions while thinking about the memory, and Luke slowly gave him a list: anger, guilt, and sadness. He continued his story, disjointed from the beginning in a way that revealed the intensity of his emotion: 'Well, I just keeping thinking about what happened, and thinking that I sent him out into that, and if I had gone out there myself, then maybe I could have handled it differently and…'

Dr. Richardson stopped him again. 'So what you're saying is, you think you could have prevented it?' Luke paused, then nodded. Dr. Richardson wrote 'automatic thoughts' on the pad, and then wrote underneath, 'I could have prevented it.' Luke continued on, describing how he had sent the soldier out on a mission into a highly dangerous area. His lieutenant had been in charge of the convoy, and had ordered the soldier to ride in a soft-shell bus, despite the fact that, to Luke's mind, it was clear that only personnel in armored vehicles had any business driving in that area. If he had gone on that mission, Luke said, he never would have let the

lieutenant send the men off in such an unprotected vehicle, and therefore the soldier would never have been injured.

Dr. Richardson prompted, 'So what's behind that thought? There's a core thought there that I'm hearing…' Luke said nothing, only sitting there looking lost, so Dr. Richardson went on, 'It sounds like you're saying, it's my fault, right? I could have prevented it, and because I didn't, therefore it's my fault that this guy got hurt.' Luke was slow to respond. His expression wavered slightly, as though his thoughts were moving rapidly, painfully, and then nodded again. Dr. Richardson went on, 'And what's the other automatic thought happening there, then? I can control situations – if I was there, I'd have control, right?' He wrote this, too, on the board. Dr. Lyndon spoke up, 'This is really common – in situations like this, a lot of times it's easier to accept guilt and to take responsibility for something that happened than to admit that you were helpless, that you didn't have any control and were powerless to stop it.'

The conversation proceeded this way for a few minutes, and Luke became more visibly angry at the lieutenant he blamed for the soldier's injury. He began to describe two other convoys in which he had taken over from the lieutenant in order to avoid potential disaster, and then, stopping suddenly, rose to his feet and excused himself from the room. There was a pause, and then Dr. Lyndon made an excuse about needing another copy of the workbook and went after him.

After a few minutes, they returned, and Dr. Richardson suggested that they use another event to finish the exercise. Luke shook his head. 'You know, it's like I said before, there's other stuff going on. But I'm going to have to face this sometime.' And the group turned back to the notepad.

At this point, another of the men, Isaac, spoke up a little too loud and too fast, as though he'd been restraining himself. 'You know, man, I just want you to know that I've been there and I respect where you're coming from, man, in dealing with officers.' He said, 'I've done exactly the same thing, where I've seen that the officers weren't in control of the situation and I've taken commend. But you have to remember, man, that you can't *take* command of the situation, you can only assume command. There's a structure, a chain of command, that's already in place, and the responsibility for those decisions ultimately lies elsewhere.'

Ernesto was listening intently, and now spoke up to say, 'You know, it seems like you're taking more responsibility for your mistakes than everybody else.' Dr. Lyndon applauded both of these additions, and Dr. Richardson wrote on the notepad, 'I'm more responsible for mistakes than anybody else,' pointing out that this thought contained an unrealistic double standard. Dr. Lyndon followed up by noting that there is only so much one can do to challenge the authority of superior officers. Luke nodded, but he wasn't totally buying it. He began talking about his training as an Army NCO: 'They tell you, 'It's *your* responsibility. I don't care what they tell the officers, it's *your* responsibility if something happens.'' He became increasingly angry as he spoke, suddenly realizing the impossible burden of what he had been asked to do.

The group continued on from there for another 45 minutes or so, dissecting Luke's sense of bearing full responsibility for an event beyond his control. Isaac spoke up to say that 'we have to remember that we're talking about combat, and something always goes wrong in combat.' He gave several examples from his own career, and then concluded that 'Murphy's law is part of combat. Murphy *lives* in combat.' He acknowledged Luke's sense of guilt and made reference to his own – guilt for the men he had lost, guilt for the dangers he had not been able to protect them from.

When the group's time was up, the clinicians brought the session to a close, but Isaac and Luke remained sitting at the table with Ernesto. I heard Isaac and Luke apologize to Ernesto for bashing officers (he had been a Captain), and heard him say that he understood. Someone asked what had happened to the lieutenant in Luke's tale, and the last I saw as I exited the room was the trio sitting at one end of the table, heads close together, finishing the story.

Re-socialization

So it is that, despite political and professional conflicts in and around the VA, clinicians and veterans generally manage to interact in relative peace within the Trauma Clinic itself, and clinicians offer perspectives on PTSD that can exert a powerful influence on veterans' understanding and management of their distress. The time-limited group therapy sessions, the classes in psychoeducation, worked explicitly to teach veterans a new way of seeing PTSD and PTSD symptoms, moving them through a highly scripted, step-by-step process of learning to view their own experiences, thoughts, feelings, and actions through a different lens. For those who chose to participate in the group encounter, it sometimes became possible to find a new way of living in the present and, at the same time, a new way of understanding the past. By the end of the session just discussed, for instance, Luke was developing a new version of his war story, one less dominated by guilt. He was in the process of discovering a fresh fury that he had been taught to take responsibility for events beyond his control. He was still troubled, but less burdened.

It is difficult to generalize what sort of impact these groups may have had on the men participating in them. Many of the veterans I spoke with were still in the process of attending and so could not reflect on their overall impact; others had already rejected the idea of the

classes, or were newly diagnosed and not yet thinking about them. Each of the classes, moreover, appeared to be slightly different in its dynamics. Even among those groups that shared leaders and a similar structure, I noticed palpable differences in the attentiveness veterans seemed to give to the clinicians' model of PTSD, and in the intimacy between group members. The group described above achieved the closest rapport among those I observed, although this may because this was the group I attended over the longest period of time (five weeks).

I have chosen to use this group as an example because I think it best demonstrates one aspect of what the group classes are *intended* to do – to take advantage of the potential for closeness between veterans themselves, and to draw on shared experiences and mutual trust. It was a recurrent theme in study interviews that the men felt more comfortable discussing their memories of war and military service with other veterans, with others who they felt had shared similar experiences and were more likely to understand. The groups offered a structured opportunity for doing just that. In addition, the classes gave these men an opportunity to recognize that they were not alone in their experiences of PTSD. Being among other veterans provided them the chance to reimagine themselves as individuals with PTSD but without weakness ('how can it be weak if it's a natural process?'), in a setting, too, where they were surrounded by the very same kind of military men from whom they had absorbed years of messages about the ideal, impenetrable service member. The men were handed a new way of talking about PTSD – in clinical terms, without stigma, and within set boundaries – and a preliminary, safe forum for doing so. New as the messages were, they came framed in a familiar package of shared expectations and unit cohesion. The classes, moreover, provided a promise of healing, in the form of something very much like a mission these veterans could work

towards together, just as they had worked alongside their brothers-in-arms on so many other missions.

I do not wish to romanticize these classes or the relationships within them; certainly some groups had members who were roundly detested by the other men, and veterans in study interviews frequently complained about this or that clinician. But given the vitriol that often characterizes public discourse around the VA, I have to say that I was deeply surprised to see how much warmth was possible in these settings, how much trust could emerge in even this contested place.

In the next chapter, I contrast the welcoming space that many veterans find within the VA's human relationships – if not necessarily within the VA as an institution – with the more complex ambivalence that veterans often encounter in larger American society. I consider the double-edged sword of disability pay in greater depth, and explore why veterans are not only revered, but also feared, in modern America.

Part III. – Navigation

Deriving a Path for Life and Illness

Ambivalence

PTSD and Perspectives on Veterans in Contemporary America

Chapter Eight

"There's a lot of people out there who ruin it for the certifiables." Chris Monroe

On a warm morning in September, 2007, I drove out to one of the small farming towns to the southeast of San Antonio, watching as strip malls and subdivisions succumbed to wide fields under a bright sky. I was heading out to meet with Cheryl, the wife of a Vietnam veteran and organizer of an informal support group for veterans' wives. Reaching the town, I wound through leafy side streets until I found a dilapidated building, home to the local veterans' support organization where the group usually meets. Cheryl was waiting at the door for me as I climbed the front ramp. She welcomed me in and then gestured me towards the main office. 'They want to meet you,' she said.

"They" turned out to be prominent members of the veterans' organization. I had already met her husband, Jimmy, at the Veterans' Forum described in Chapter Six, and so I recognized him sitting in his motorized chair at the corner desk. He has lung trouble, which Cheryl blames on Agent Orange, and has been on oxygen for ten years. The thin clear breathing tube was crossed beneath his nose, extending to a tank just behind him. He greeted me and introduced me to the other two men there: Jonah, with a red plaid shirt and long gray beard,

and Greg, with a small neat mustache, who said 'God bless you' as he came over to shake my hand.

Jimmy introduced me around as a young woman writing on PTSD and how it affects families, and then passed me a booklet he drew from a drawer in his desk, on PTSD and families. Then he and Jonah began to tell me what they thought I needed to know about PTSD, and about Vietnam. They began with the VA – which had claimed not to know about PTSD twenty-five years ago – lying, they said, in an attempt to convince the veterans they were crazy: 'And they almost succeeded!'

Vietnam veterans can't trust anyone, Jimmy said, because the only people they had been able to trust out in the bush were other Marines – he and Jonah had been Marines, and they gave the mild Greg a hard time for being former Army – and when they came home they hadn't even been able to trust other citizens. I don't remember how Jane Fonda came up, but Jimmy said that he had never met a Vietnam veteran who has forgiven her for speaking out against the war, who doesn't think she should be tried for treason and executed, and said he himself would shoot her if given an unobstructed view.[1] They complained about then-President Bush's management of the wars in Iraq and Afghanistan, and about how poorly service members are paid for the work they do. They repeated several times that PTSD is *not* a mental illness.

Jonah said, 'It's not like schizophrenia or paranoid schizophrenia or any of those others.' Jonah asked me, 'Do you know what PTSD is?', and when Jimmy ignored his question and

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[1] Carol Burke has explained the continuing hatred for Jane Fonda among active and former military personnel as a way of reassuring "even the lowliest plebe of his insider status by expressing collective disdain for an outsider" (Burke, 2004: 177).

continued talking, spoke over Jimmy to say, 'I don't want her to write that PTSD is a mental illness because it isn't.' Cheryl walked back in about then – she had gone out of the room for a moment – and nodded her agreement. 'It's not a mental illness, it's not a genetic defect you're born with,' she said, before adding, 'If you want to see everybody in here hit the floor, you just have a car backfire outside that window.'

After a few minutes of conversation that continued in this disjointed way, Jimmy turned to Jonah and asked, 'Did you ever kill any babies, over there in Vietnam?'

'No,' said Jonah.

'Neither did I,' said Jimmy, 'but when I got home I got called a babykiller.'

'I got called a babykiller even by some folks in my own family,' said Jonah.

Jimmy continued, 'It only happened once, but…' and Jonah finished his sentence, with a significant look at me, 'It only happened once, but I remember that, and somebody was going to get hurt.'

At this point Greg stood up suddenly beside me and, taking my hand, asked if he could pray for me. I said yes, and he put one hand on my shoulder, bowed his head, and prayed for a minute or two, asking that I be blessed in the work I was doing, and that those serving in Iraq and Afghanistan be taken care of and receive all that they need. His voice became choked with tears partway through, as he spoke of the young men and women serving now, and he was unable to continue for a moment. I waited for him to recover, squeezing his hand a little. 'Amen,' he said, finally, and I echoed him.

Greg's prayer seemed to come as a response to the memories retold by Jimmy and Jonah – of the names they were called after Vietnam, the betrayals they felt at being greeted by a vehement anti-war movement upon returning home. By contrast, veterans of Iraq and

Afghanistan are often spoken of as heroes, as those who have served and sacrificed and earned the thanks (and prayers) of a grateful nation. During fieldwork, it was not unusual to hear public figures say things like, 'There are two men who've sacrificed their lives for you. Jesus Christ died for your soul, and the American G.I. for your freedom,' thereby equating soldiers with Christ. In previous chapters, I have discussed how the public pressure created by this sense of honorable obligation has had a prevailing impact on the way certain American institutions respond to veterans' needs. But even recent veterans, for all the 'Support the Troops' bumper stickers and military movie discounts and special home loans and VA resources, are often met with uncertain gratitude upon coming home. At times they run up against other undercurrents – of suspicion, derision, sometimes fear – and these may have their own consequences for veterans living with PTSD.

In this chapter, I turn to the issue of what happens when veterans of Iraq and Afghanistan encounter darker stereotypes of veterans in contemporary American life. Exploring how some veterans with PTSD describe the struggle to determine their own rights and obligations amidst the legacy left by other service members – both those of Vietnam and other eras and those who have placed a more recent stamp on the public imagination – I have found that veterans' concerns reveal underlying uncertainties about what combat PTSD means for their sense of themselves as men of honor.

Because veterans, like most of us, orient as moral beings in relation to the examples available in their social and cultural realms. These may include both positive examples – personal heroes, mentors and friends – and negative ones – individuals or images that represent an idea of what *not* to be. In making decisions about how to navigate this complex moral ground, veterans also make decisions about how they will enact their identity as veterans, and

as individuals in distress. How veterans negotiate these choices can have profound implications for their experience of PTSD, as well as the actions they take in response to it. So it is that, in making everyday choices about care-seeking, applying for compensation, and making sense of their current selves and past experiences, newly returning veterans may find themselves struggling against a backdrop of cultural ambivalence in which veterans are associated with both honor and violence, heroism and atrocity. They may find this ambivalence becoming their own.

Follow the Money

I introduced the issue of disability compensation for PTSD in Chapter Six, examining how it has become part of the political backdrop for relations between clinicians and veterans seeking care at the VA. However, compensation also plays another role in shaping how OEF/OIF veterans approach care-seeking for PTSD illness, and the way they identify with PTSD more broadly.[2]

This happens in what are, first, the obvious ways. Veterans receiving a PTSD diagnosis may file a claim with the VA for compensation, which sets up a bureaucratic process that may take months or years to resolve. Ideally, the claims of OEF/OIF veterans are fast-tracked for quick processing as part of the VA's effort to provide expedient services to its newest veterans. Adam's claim, for example, was resolved in four months. Other OEF/OIF veterans in the PDS

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[2] Talking about compensation inherently brings a sort of stickiness to any conversation about PTSD, as though speaking of the monetary benefits associated with a PTSD diagnosis somehow undercuts a recognition of the distress for which such benefits were originally intended to compensate. Before broaching this complex subject, therefore, I first laid a groundwork in which PTSD could be understood in other ways – as a form of intense suffering, as a series of ideas about veterans as men and as individuals in distress, and as a professional and authoritative way of understanding a specific disorder. Nonetheless, it would be wholly untruthful to suggest that disability payments don't play an important role in shaping the lives of PTSD-diagnosed veterans.

study received similarly quick responses, although even four months may be a long time for those unable to work and living on their savings or credit cards.

Still, these relatively speedy turnarounds have not always been the rule. One veteran at the Congressional Forum (described in Chapter Five) shouted that he had been battling with the VA over his compensation claim for '24 years, man!' This can be a sore subject for the VA. One VA Compensation and Pension (C&P) specialist I spoke with, while gregarious on the many problems in the system of awarding disability claims, was firm in dismissing those veterans who claim that they've been working on a claim for 10 or 20 years without resolution. "We give everybody an answer. You've gotten a denial, but you've gotten an answer." Nonetheless, it is hardly unheard-of for claims to be lost in the mechanics of the VA benefits system, and there are other obstacles as well. The documentation needed to prove a veteran was in service overseas or to demonstrate trauma exposure may be missing or unavailable. The memory problems experienced by many veterans with PTSD may make it difficult to ascertain the timeline of key events. One social worker pointed out how upsetting the process of having to prove a disability could be: '[Veterans] just want acknowledgement, they just want their integrity, they want to be believed. They say, 'People think I'm lying, or I'm trying to pull one over.' Think about it, to suffer like that and then have people not believe you.'

Such battles over due compensation can remain a source of ongoing stress over time. When Josh, a former Marine who was wounded in Iraq, was diagnosed with PTSD and traumatic brain injury, his wife Laurie filed a series of claims applying for his life insurance and appealing his disability award, which came back at a lower level than they thought appropriate given that he is unable to work. She spoke of trying to find time for this additional work amid her other duties, filling in as patient advocate and paper pusher as well as full time mother and care-giver.

Beyond the stress of the application and appeals process, there is the fact that the difference between receiving benefits and not receiving them is measured in the quality of veterans' lives. Josh and Laurie's future, and the opportunities they will be able to supply for their son, will be shaped in part by the compensation they receive over the coming years. Veterans reported using this compensation in different ways, depending on how much they received and how great their need was. Some needed every cent of the funds to pay the rent and keep food on the table; those who were unemployed sometimes struggled to manage even this. One veteran had used his disability payments to buy a house for his family, years ahead of when he had thought it would be possible. Another, an outlier who had made in excess of $100,000 as a financial analyst the year before, admitted that he had no need for his disability pay as a source of income. Beyond compensation, other benefits could also serve as an important resource. For example, veterans who are considered to be 100% disabled may extend their healthcare to spouses, and several of the veterans in this study had wives with chronic health conditions and no health insurance. For many veterans, then, the money and benefits they receive make an important contribution to their ability to live a satisfactory life.

However, for some veterans newly separated from the military, the issue of compensation payments could be associated with concerns as well as potential benefits. At a chaplains' training workshop I attended in 2007, one of the chaplains asked a VA clinician about what he called the 'paradox,' the notion that the very same soldiers who do not want to be labeled with PTSD during their service may end up wanting that label when they become veterans because of the disability pay. The clinician demurred in answering, saying that many of the OEF/OIF veterans she works with don't *want* compensation. She suggested – although this was not explicitly part of the question – that problems related to needless compensation-

seeking were more common among older veterans. She expressed some compassion for older veterans, pointing to those who lack job skills or who have been receiving compensation for many years and are now nearing retirement age with no pension or savings. But the issues, she thought, were different for OEF/OIF veterans. She did not specify what those issues might be.

Certainly, PTSD compensation may mean many things for veterans of any age. At the Congressional Forum, one older veteran spoke up to say how nervous it made him every time his provider asked him about PTSD symptoms; he was terrified of losing the disability pay on which he was utterly dependent. Other Vietnam veterans I encountered spoke of compensation as an earned right, or as a right for which they were humbly grateful, or, rarely, as an opportunity. One day as I was sitting around at the VA, an older man came up to a friend beside me and began describing good-humoredly how he had been getting all he could out of the VA 'for 20 years!' He bragged about how he gets his 100% compensation from the VA on top of the worker's compensation he receives for an old work injury, and then said that now he's about ready for Social Security and how – wide grin – 'they're going to pay up!' Standing there in his leather vest with its many patches proclaiming him a Vietnam veteran and an advocate for POW/MIAs, he looked like the consummate picture of a disenfranchised veteran, only considerably more cheerful.

As if in fear of the image this man seemed to embody, I heard the question of what compensation means to younger veterans raised continuously in VA and military settings during fieldwork in 2007-2008. At one workshop, a conversation sparked between clinicians worried that Vietnam veterans might find it difficult to seek treatment for PTSD because it required giving up both an identity – like Jimmy's and Jonah's, that of the suffering veteran abandoned by an ungrateful nation – as well as the secondary benefit of financial compensation. At yet

another workshop, a researcher for the Army asked a psychologist treating active duty service members how she was dealing with what he called 'the social learning theory of PTSD.' He explained this theory (without saying whose theory it was) by saying that service members get 'positive reinforcement' for PTSD when they return from combat, receiving both treatment and disability pay if they exhibit distress. The clinician replied that the idea of 'positive reinforcement' for PTSD was completely inconsistent with her own experience among OEF/OIF returnees. She said that, on the contrary, most of the people she saw were worried about being stuck with the label of PTSD, because of its 'associations with Vietnam'.

This idea of 'associations' seemed to keep coming up alongside discussions of compensation. On another occasion, a researcher told me of hearing from Army nurses that some OEF/OIF veterans were refusing to even go to the VA because they 'associated it' with Vietnam veterans who faked or exaggerated symptoms in order to get compensation. The researcher herself attributed this to what she called 'lore' about veterans who had gone to the VA or its satellite Vet Center and been told by other veterans what they needed to say in order to get a PTSD diagnosis and compensation. She explained this passing on of information as a way of adapting to an ineffective compensation system – as a means by which veterans had for decades countervened a broken system. When I mentioned the researcher's theory to another clinician, he said, 'Oh yeah. Guys tell me that all the time – they don't want to be like those crazy Vietnam vets. They don't want to associate with them. They don't want to end up like them.'

All this raises the question, what is it about Vietnam veterans that some OEF/OIF veterans don't want to be associated with? What fate is it that these OEF/OIF veterans are trying to avoid? Certainly, over the 35 years since the conflict ended, the Vietnam veteran has

come to symbolize many things in American culture. Vietnam veterans play a regular and important role in the more prestigious venues of public life. They serve in political office, often arguing that their status as veterans makes them better suited for the job. (What would the narrative of Senator John McCain's 2008 presidential campaign have been without his history as a prisoner of war in Vietnam?) Vietnam veterans are a fixture in film and television, where they may be portrayed as heroes – as in "Rambo" – or as the butt of jokes – such as Walter Sobchak in "The Big Lebowski", who compares everything (including bowling) to his experiences back in "'Nam". Even in the most heroic incarnations, however, the Vietnam veteran is typically portrayed as a damaged man. Vietnam is broadly associated in the national imagination with failure: a failed war; veterans who failed to reintegrate after their service, too often becoming mired in family violence, substance abuse, and homelessness; and a VA system that failed to provide adequate care and support for too many years.[3]

PTSD itself remains saddled with much of this sense of failure, emerging as a way to explain what went wrong for a visible minority of these men. A retired Army chaplain I encountered, Chaplain Matthewson, even had a theory that there was, among Vietnam veterans, a 'cult group' who love the idea of having PTSD, calling it a 'victimology' that could be used to explain any problem in life. He said that he doesn't refute the idea that some people are genuinely affected by PTSD, but estimated this number among the current OEF/OIF group at less than 1%, as compared with the 11-19% of OEF/OIF veterans found to demonstrate PTSD

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[3](Grossman, 1995); Allan Young has argued that the negative image of Vietnam veterans extends back to the early 1970s, when: "…the American news media reported what seemed to be an epidemic of suicides, antisocial acts, and bizarre behaviors committed by Vietnam War veterans… Psychiatric authorities were said to have discovered unexpectedly high rates of mental health problems and self-destructive behaviors among these men, including alcoholism and drug addiction. The 'crazy Vietnam vet' – angry, violent, and emotionally unstable – had become an American archetype." (Young, 1995: 108)

symptoms in epidemiological studies.[4] I asked him what he meant by 'cult', and he looked uncomfortable, but said that he was talking about 'a lifestyle and methodology that revolves around that traumatic stress experience and that becomes who they are.' He said that, at the VA, one may encounter this attitude among some of the Vietnam vets, calling this the 'Vietnam cult.'

Thus Matthewson linked having PTSD with identifying strongly as a Vietnam combat veteran. Other veterans also expressed reservations about becoming defined by their status *as* veterans. One poked fun at older veterans who hang around at the VA wearing hats or t-shirts bearing the insignia of their unit or their veterans' group or their medals. He seemed at first to scoff a little at these men, but then said that he didn't mean any disrespect. 'What you wear defines critical moments in your life,' he explained, 'Some of these guys aren't able to separate themselves.' Another soldier still on active duty made a point of saying he hopes that, in twenty years, he isn't the guy "in the hat," that guy who never found a way to make the rest of his life as satisfying as his memory of the military. A wounded veteran spoke of never wanting to be as helpless as the older veterans he had seen at the VA, who he described – in one poignant example – as squabbling over bingo cards.

And so, for younger veterans looking to older veterans as role models and living caveats, such acts as seeking care at the VA, applying for compensation, or even identifying too actively as a veteran could all be seen as risking a brush up against the characteristics they disliked in older veterans or – more specifically – against the damaged legacy of Vietnam. The VA recognized this concern early on and responded by setting up separate therapy groups for

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[4] (Hoge, et al., 2004)

Vietnam/Korea/WWII and Iraq-era veterans. Whereas Vietnam veterans like Greg were often deeply concerned about the well-being of Iraq veterans, many Iraq veterans remained hesitant to embrace their older counterparts too closely.

These suspicions were, at times, mutual. Brian complained that many older veterans – "especially the Vietnam era guys" – are suspicious of PTSD among younger veterans. "I don't go to my VFW anymore because I don't want to hear their shit. A lot of them think that because you didn't spend 12 months and 15 days in the bush, that you don't have enough stressor in your life to qualify for PTSD."

"They'd say that to somebody who's been in Iraq?" I asked.

"Oh yeah, in a heartbeat. I've sat there in my VFW and some dumbshit's telling me, 'Oh, [Iraq's] just a Nintendo game.' So I'm saying to myself, 'Oh yeah, you're a genius. Did you not watch the footage?'" Another veteran, and current VA employee, explained that he saw such veterans as clinging to a lasting indignation over past mistreatment: "I think that they're still holding on to past problems that the VA had with them. Yeah, we fucked up. We know. We've admitted it. We're trying to fix it." But Brian remained frustrated. "Don't tell me 'Your war was a push-button war.' I carried the same M-16 you carried, buddy." Even so, he recognized that this represents "a very small minority. Because most of the Vietnam veterans I know are very supportive of the soldiers coming back now. And they're like, 'Hey, I'm glad you guys are okay. Welcome home.' You know. Most of them are that way. You just got those shitheads that can't get over something that happened to them thirty years ago."

Brian's irritation was real, and shared by other veterans, but this should not be taken as a sign that OEF/OIF veterans as a rule lack respect for older veterans. In November 2008, I saw an Iraq veteran begin a public speaking engagement by saying thank you to the Vietnam

veterans who fought for their rights in the 1970s and 1980s, paving the way for the current generation. Others were swayed by the same respect for military traditions that led them to join up initially; these values still held true. Jesse remembered his shock at seeing an Iraq-era veteran talk roughly to older veterans at the VA. "The one guy didn't want to wait in line, and he was trying to see the Benefits Advisor. So he got in this big ole argument with the Benefits Advisor – which is probably the worst person you can do that to. And some Vietnam veterans and a World War II veteran were right there and he was telling them they were too old, don't need to be seen." Jesse was disgusted. "'You just caused big problems for yourself there. You're embarrassing yourself. You see me, I'm young, heck," – and he mimed apologizing, distancing himself from the other man – "'I'm not part of this.'"

A number of the men in the study had, in fact, turned to Vietnam veterans – their fathers, uncles, friends, etc. – in an effort to better understand their own experience with PTSD. Jesse had sought out an ex-girlfriend's father, a Vietnam veteran, because he found some comfort in "talking to a Vietnam vet, laying out your experiences, because they can understand it." Although he, like almost all of the veterans I spoke with, said he finds it "easier to talk to veterans," he had also found that, in creating a space of shared experience, the era of service mattered less than the type of experience in the service. To his mind, whether or not another veteran had been in combat mattered more than the era of that combat.

Still, this esteem could be a double-edged sword. Adam, a Marine from Houston who spent a combat-heavy tour in Iraq, held such admiration for older veterans that it made him hesitant to seek care at the VA. His respect for those who came before only exacerbated his shame over suffering from PTSD rather than some more visible wound. When he moved to San Antonio, he had already been receiving private psychological care for more than a year. But

when it came time to start the process of transferring his care to the San Antonio VA, he said, "I couldn't bring myself to do it. I think it was still that macho attitude – but I had been getting help, and that was what was odd about it. I had accepted – psychologically, I had accepted help. I still couldn't come to the VA. I just didn't see myself as worthy, in a sense. Because when I think of the VA, I think of veterans. I think of old guys like my grandfather or Vietnam veterans who lost legs or arms or have truly physical debilitating injuries, and I guess I just didn't see PTSD as an injury." He had grown up with the stories of his grandfather, who was a "Marine in World War II and Korea. He fought on Midway and then he was in the Korea after the Cho-Sun Reservoir. He was in the artillery." He grew up reading "Vietnam era books. I always loved the military and wanted to join." He had sought to be like the veterans of his childhood, and this desire did not fade away after his service, when his ongoing respect for older veterans became yet another piece of his shame over having PTSD. A physical injury would have been worthy of his proud military heritage. PTSD was not.

Derek – who perhaps worried less about stigma because his titanium prosthesis left him with a visible wound – found pride rather than shame in thinking of other veterans. He said, "It's a little elite club. It's a camaraderie. Walking through the halls [at the VA], you can recognize 'em by the hats and the haircuts and we're all brothers and sisters. That's a really nice feeling, and one of the reasons I stayed in San Antonio was because people here take care of us unlike anywhere else in the country."

In contrast to Adam's shame about having PTSD, his feeling of weakness in contrast to the older veterans he had revered, Derek's PTSD gave him access to the most important Vietnam veteran in his life, his father. Derek's father abandoned him and his mother when Derek was only five, dropping contact so totally that it was like "he vanished off the face of the

earth." They later learned that he died young, in his mid-forties, forever denying Derek the opportunity to find and reconnect with him. Derek said that, until he got back from Iraq, "It was really really hard for me to come to grips with it." While he was deployed, Laticia hunted down some information on his father. It turned out that his African-American father had earned three Purple Hearts in Vietnam, beginning the war as a combat medic before learning to fly rescue helicopters, at a time, as Derek points out proudly, "when there were very few black helicopter pilots."

After Derek was wounded and, later, diagnosed with PTSD, he had a long talk with his mother, who had her own memories of the husband who had disappeared. Seeing her son in the hospital, learning about his PTSD, Derek thought it had "really hit her…what really was going on with my Dad. So it definitely added closure to my Mom seeing how I was going through things, and it really helped me understand that it wasn't me that made him up and disappear." In his Mom's stories about his father, he found it newly possible to link his own symptoms to his father's experience. When Derek was just a baby, he said, "We lived by one of the Air Force bases, and every time one of the planes came low, [my father] would dive under the bed. And I have the reverse of that. When I hear helicopters, I feel absolute peace. Anywhere you were going [in Iraq], if we had a helicopter escort, we were safe." As his knowledge and understanding of his father grew, his father emerged out of the shadows and became more than just a Vietnam veteran who had abandoned his young son; he became a man whose accomplishments Derek could take pride in, even as he found it easier to understand his vulnerabilities.

So although OEF/OIF veterans expressed a wide range of feelings about older veterans, and Vietnam veterans in particular, what became clear in the course of the study was that

nearly every OEF/OIF veteran diagnosed with PTSD found it necessary to define himself in relation to the legacies of older veterans – both positive and negative. The attitude each veteran took towards compensation was one piece of this process. The decision whether or not to seek disability pay for a diagnosis of PTSD became part of figuring out how they felt both about being a veteran and about having PTSD.

One 25 year old veteran, Kevin, was hesitant to put in a claim for PTSD, although he was seeing a psychiatrist and taking medication for his symptoms, and although he had no such compunctions about the 30% disability pay he was receiving for injuries to his back and knees. I asked whether he was filing for PTSD, and he said, "I put in for it, but I had a real hard time about it. I just now did it, a few weeks back."

"Why so tough?" I asked.

"Because it's just pretty tough. It's kinda scary going in there and admitting you have a problem like that. Like a mental problem. Or even just asking for money. I wanted that money to more or less go to other people who needed it, that were like missing limbs and stuff like that." Seeking compensation was, for Kevin, a way of admitting to PTSD that felt more serious than simply seeing a psychiatrist or taking medication, and seemed like it might take something away from those with physical injuries, those who, in his mind, "needed it."

As I have already noted, conversations about compensation – whether with veterans or those who work with them – were often layered with an underlying specter of claims that might be frivolous or fraudulent, or even just an unnecessary drain on taxpayer funds. One veterans' advocate reported that he had heard civilian VA employees say to patients, in the midst of some kind of conflict, 'Well, my tax dollars pay for your healthcare!' He was disgusted by this and said that such an attitude can *exacerbate PTSD*, not to mention that these veterans had fought for

American freedom and therefore had every right to financial support. Still, every VA staff member or veterans' representative had their own ideas about which claims were reasonable and which were not. Even one of the most vehement advocates I encountered, a woman working with wounded soldiers, acknowledged that there are problems with the compensation system. She drew a comparison between TBI and PTSD, saying that those with TBI struggle because nobody believes their injury is real. 'They're seen as a potential rip-off, like PTSD,' she said. She noted that the only book she sees regularly taken out of her facility's small library was one that describes the symptoms of TBI and PTSD. She says she has seen soldiers write down the symptoms so they can go in and make their claim. 'But,' she emphasized, 'this is just a few people.'

Veterans recognized that their PTSD claims might be seen as fraudulent, and found their own ways of managing this distrust. Adam talked about putting together a successful disability claim, and then suggested that, "If you don't want to do it – because you don't need it or whatever – then don't do it. Don't abuse the system just to do it. But if you need it, do it, absolutely. That's what it's there for." He was pragmatic. The system is there to provide financial assistance to those who need it. It is to be used when necessary, but not to be abused. Still, most veterans were aware of how the system worked. When I asked Lucas about what he had thought when he was diagnosed with PTSD, he grinned sideways and answered immediately: "That I got benefits?" Another veteran talked about how he and a friend "both enjoy putting it over on the VA – like trying to get more money out of them."

Chris was, himself, on the receiving end of some advice about how to get compensation. "One time I was …downstairs at the pharmacy, and a couple of older veterans were asking me, 'Oh, did you fight in Afghanistan? What you got to do is you got to tell 'em you can't sleep at

night, you're having nightmares, and they'll give you disability for PTSD. That's what you got to do.' And I remember thinking, 'Well, I do. And it's not fun. And I would give up every penny of the disability if I didn't have to live through this shit that I'm living through.'"

Sensing he was more angry than he was admitting to, I risked offering another response: "Oh, and by the way, fuck you!"

He seconded this immediately – "That's how I felt!" – then he paused for a minute, taking a breath. "I didn't want to ever be that guy, though, you know what I mean? There's a lot of people out there that ruin it for the certifiables." He laughed, and began talking about the care he had received at the VA. "It took a long time, but in the whole scheme of things, [that time is] just a drop in the bucket. It didn't take me thirty years, and I'm not a lost cause, you know what I mean?" He went on. "Why would I want to suffer for forty years for a paycheck? Vietnam vet guys are suffering for that, and I don't know why. One thing I've never asked about is how much is disability going to cost me, because I would give it up in a heartbeat if they said, 'Hey, we've looked through your records and it doesn't seem like you're disabled anymore. You've got a good paying job.' I'd say, 'You know, you're probably right. Thank you Veterans' Administration because I didn't want to live like that, or die like that.'"

Chris sums up a lot in a few words: The older veterans who reached out to him as another veteran, suggesting a way he could get compensation for his service. The way he recoiled from their offer, saying he "didn't want to ever be that guy," and that he would gladly give back the money "if I didn't have to live through this shit." His fury at those who "ruin it for the certifiables" by taking advantage of a system put in place to care for those who are genuinely disabled. The bullet he feels he dodged in getting care early, unlike so many older

veterans, before he wasted thirty years as a "lost cause" or spent forty years suffering for a paycheck.

Chris recognized that he was fortunate to have had professional care available when he needed it, in contrast to so many of those who were left without support after Vietnam. In fact, back when Chris was leaving the inpatient ward at Lackland Air Base, when he was starting the paperwork to retire from the Air Force, someone told him the VA was "really trying to help veterans from [Iraq and Afghanistan], trying to push them to the head of the line." He recalls thinking, "'That makes sense. They can keep people from being like all of these messed up Vietnam veterans over the last 30 years, that may or may not have gotten treatment. They can try – not to write them off – but at least try to head off the long-term problems they're having with the Vietnam vets.' That made sense to me. I remember thinking, 'At least the VA's trying to do right by modern vets.'"

These words, he said, began ringing in his head when he fell apart a year later, and this is how he explains seeking care at the VA. He envisioned what his own future might look like if he didn't seek care, reflected in all of those "messed up Vietnam veterans." And so he chose to take advantage of the VA's attempt to push OEF/OIF veterans "to the head of the line," and made a different set of choices, choices that he feels have led him to a place where maybe he doesn't need the disability pay anymore. And so it was that the past legacy of Vietnam and the perception of older veterans remained closely tied with recent veterans' decisions about whether to seek care at the VA and whether to apply for PTSD-related compensation.

There is a cyclical nature to these relationships between past and present, and newly returning veterans will themselves create the past for veterans of the future. The stakes became clear in December of 2008, when a San Antonio newspaper reported that a local Iraq

veteran, Brian Culp, had been charged with faking his military record in order to apply for Purple Heart license plates and PTSD compensation from the VA. He falsified documents asserting that he had been wounded in Somalia in 1993, that he had served as an Army Ranger, and that he was the recipient of a Bronze Star with valor, all of which was untrue, although he had served honorably during two tours in Iraq and become locally known for the hunting and fishing trips he led for wounded veterans. Culp's fraud was identified when he attempted to enter Lackland Air Force base using a forged military ID, though a number of local Army Rangers were already investigating his history based on their sense – upon "vetting" him – that some of his stories didn't ring true. His lawyer pleaded for clemency at his trial, noting that the article identifying Culp had received more than 100 comments on the newspaper's online portal and had triggered not only a public shaming but also threats on Culp's life. Speaking in his own defense, Culp pleaded that a recent divorce, untreated depression, and a long history of insecurity had prompted him to embellish his military history. Culp was found guilty and sentenced to three years of probation.[5] He remains under investigation for false claims resulting in $11,000 in disability payments received from the VA, a felony offense.

Killer

However tainted with its mixed bag of honor and shame, disability compensation bears none of the darker stigma associated with violence among veterans, from which PTSD remains inseparably linked in both real and imagined ways. PTSD's ties to violence are two-fold: it is the

[5] (MacCormack, 2008a, 2008b)

exposure to violence that is understood to bring about PTSD, and PTSD is widely understood to make veterans more violent.

It is worth noting here that some scholars – Lt. Col. Dave Grossman most prominently among them – have proposed that *committing* acts of violence, and killing in particular, may place veterans at increased risk for PTSD. Grossman has written extensively on the consequences of teaching military personnel to kill, suggesting that killing is an unnatural act for human beings and that conditioning young men "to engage in an act against which they had a powerful resistance" can have profound psychological repercussions.[6] More recent work by William Kilgore and colleagues has found that soldiers deployed to Iraq who reported having killed in combat were more likely to show an increased propensity to risk-taking upon the return home.[7] Among the veterans in the PDS study, no significant differences in current PTSD symptoms emerged between those who reported killing and those who did not. Despite Grossman's apprehensions, killing did not predict more severe psychological distress among these veterans.

Nevertheless, the understanding of combat veterans as men who have engaged in killing has powerful cultural resonance. Jimmy and Jonah remained furious at having been called "baby-killers" some forty years after the event.[8]

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[6] (Grossman, 1995: 283)
[7] (Kilgore, et al., 2008)
[8] The epithet they found so reprehensible remains subject to some debate as to its origin and prevalence. Sociologist Jerry Lembcke has claimed that the term may never have been used against returning Vietnam veterans, arguing that accusations that war protesters spit on and hurled invectives at veterans was part of a myth conjured up to discredit the anti-war movement (as was, he suggests, PTSD)(Lembcke, 1998). For a rebuttal to this claim and an interesting conversation on its history and legacy, please see: http://www.slate.com/id/2159470/#sb2159648. Whether or not the term was ever used against veterans during the Vietnam years, it has been handed down as part of the soiled memory of that conflict. Along with the term has come the lingering notion of Vietnam as a dirty war, in which service members

Neither Iraq nor Afghanistan have – as of the Summer of 2009 – yet become linked with massacre in the American imagination. The wars in Iraq and Afghanistan, though, have brought their own revelations: of prisoner abuse at Iraq's Abu Ghraib prison in 2004; of the 2005 killing of 24 civilians by a group of U.S. Marines in Haditha; of the American soldier who convinced members of his unit to assist in the rape of a 15 year old Iraqi girl and the murder of her family.[9] Widely reported around the world, these stories serve as reminders that American service members sent to combat in Iraq and Afghanistan can and do commit violence, and may do so in ways that fall outside the rules of engagement.

The OEF/OIF veterans in this study were not unacquainted with such violence, and sometimes found it necessary in interviews to explain certain incidents, although I never asked them to. I have already spoken of how Chris left Afghanistan after attacking a prisoner he was escorting to another unit. Recalling the incident, he remarked that "this was before all of the Abu Ghraib stuff," but said, "It had been a bad few months. There had been a bombing and I had seen a lot of people killed. There had been a bombing in Kabul and I had been pretty helpless with that – we weren't able to help anybody. We'd been ordered not to intervene. The Northern Alliance was killing a lot of prisoners, torturing them, and they were doing it but some of it was pretty gruesome." Within this chaos of war, he says, "I just was moving prisoners and within a situation I shouldn't have been in, and was put into a situation I shouldn't have been in charge of, just by virtue of rank." Although clearly uncomfortable as he spoke, he did not

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committed sometimes horrible violence against the innocent and the vulnerable, as in atrocities like that at My Lai, where more than 300 unarmed men, women, and children were killed by a company of soldiers in 1968. Finally, in interesting contrast to such documented horrors, Allan Young (2007) has written recently of the "self-traumatized perpetrator" – the Vietnam veteran who confesses participating in atrocities that never happened – as a transient mental illness in American society.

[9] (Press, 2006)

apologize for what he had done; he did not express remorse. He said, "I wasn't equipped to – either with training or mentally equipped to do the job – and a prisoner resisted and I just lost control." He says he doesn't know what happened, exactly. Just that he "definitely hurt the guy." In the context of the interview, it was clear that he did not retell this story in an effort to rationalize his violence, but rather as part of explaining why he wished he could go back to Afghanistan. He felt that being sent home early had left him with work unfinished, a mission left incomplete.

Carlos said that, initially, being in the military had taken some of the violence out of him. "I was a shy kid," he said. "I was mean, but I was shy. I don't know how you can be both, but I was. Very undisciplined. Very – I was a danger to myself. I used to carry guns, knives. I used to rob people. I was a bad kid. I was in gangs, I used to fight. [Being in the military] changed me." Though after time running a riot team in an Iraqi prison, he says, "The last few years, it's like I reverted back. I try to tell myself that it was necessary, but it's hard to believe I needed to do some of the things I did in Iraq and Afghanistan. But I'm trying to get myself to understand that I did what I did to survive."

He remembers that when he found out he was going to be a prison guard, he was relieved. "I told my guys, 'at least we're not going to be doing any gun trips.'" But it turned out to be worse than that. "The minute we walked into the prison – riots. Fighting, hand to hand combat, you name it. Crazy. And then probably a month later we started getting mortared and rocketed. So we were experiencing the war two-fold. Fighting the prisoners and then trying to ignore the explosions on the outside. Base was being attacked. It was kinda rough."

Like Chris, Carlos speaks of his own war violence in relation to the stressors around him. "I had a lot of friends that were there that were with me – half of us went to the prison and the

other half went to the perimeter, fixed positions. So you know I was always worried about my buddies." Meanwhile, he became the "boss" in the prison, "So every second of the day was that prison. It didn't matter what I needed to do – as soon as something would happen I'd have to get up and run back to the prison." He says, "The thing that bothered me is that it became very easy to pull a trigger on another human being. Very disturbing how the feelings I felt doing it – I wasn't afraid to do it. I wasn't cautious. As a [military policeman], pulling my weapon I always got this scared-excited-cautious feeling. Not pointing my gun at my own leg and shooting myself. Not shooting someone accidently. It was very cautious. And there it was – no caution, no fear, nothing. Just – I don't know how to explain it – just primal."

He recognizes that the war brought about changes in him. "And it didn't start out that way. I started out being this real professional NCO, making sure my – most of my troops were kids. Eighteen. Checking their feet, making sure they're okay. Making sure they were eating. And after a few riots I turned into, I don't want to say tyrant, but…I was…they pretty much called me 'the Shooter.' Because that's pretty much what I did. We used to go in and count prisoners, and I was the one with the shotgun, and if anyone got out of line it was pretty much one or two yells and then 'Boom!'" The rounds he was using were supposed to be nonlethal, but he acknowledged that, "They still kill people. And we killed a lot of prisoners, with something that's not supposed to do that. Of course a lot of it was on accident, but… I don't know. I became very guarded, very high-strung. What it did with my troops was it made them the same way, because they'd do what I would do. And of course I used to fight to make sure they were protected and they protected themselves."

There came a time when – event piling upon event upon event – Carlos recognized that something was wrong inside him. The realization came after a bomb attack on a convoy he was

running, transferring prisoners to Baghdad in early 2005. When the IED exploded, "[It] blew the whole bottom of our bus out. And at the time I had 41 Iraqi prisoners – *mujahideen*, whatever you want to call them, they were terrorists – and I didn't care at all. And I knew I was afraid for myself, and my partner, who was a real young kid." But the explosion itself "didn't bother me at all. Pulled my weapon out, started pointing it at my prisoners – who was injured, who was dead. Started yelling and screaming at them not to move, pretty sure they were scared, but [the IED] didn't faze me in the least."

"That night we got mortared. I found out I'd lost my rifle, all my ammunition. It was on the bus. So I had a pistol and one magazine, and we were getting hit hard. So I figured I should have been scared, I should have been trying to get more weapons. And all I really did was get all my people together and tell them to take cover. I didn't really even think about my lack of ammunition – just made sure they were fed and they had cover, and then I left them. I did something stupid. I climbed up on top of one of the buildings to see the battle – just to keep my people informed, to see where the battle was …and all the things they taught me about battle I was defying. Highlighting myself. Getting on the roof. Watching instead of listening. Smoking cigarettes. Drinking beer. I climbed on the roof with a six pack of beer and cigarettes to watch the battle. It wasn't until they saw me and I started getting fire that I realized that what I was doing was insane.

"So I got outta there. I pulled my weapon and started returning fire and realized, I only got 10 more bullets. I'm crazy up here. So I got down and started to realize that something was happening to me that wasn't right. That I wasn't thinking clearly. I was doing things that were…detrimental to my health." He laughed, and said, "I returned back… very angry after that. I witnessed an Iraqi girl shot with a grenade launcher, and it started making it worse for me."

He says that the shooting of the little girl "really made me lose control of my anger. And I guess at the time some of my NCOs noticed it and they moved me outside of the prison, to a place searching vehicles. So they got me away from the prison, which was good, because I was getting very, very, very – I don't know what the word is. I guess violent. Not physically. But verbally. Just being real short with them. I guess the fact that I almost died because of that bomb and because of watching this girl be just senselessly injured just made me snap."

Several years after this 'snap' – after finding himself on a roof under attack, drinking a beer and smoking a cigarette as he watched all hell break loose around him, and after surviving a bomb attack only to watch the maiming of a little girl – he still struggles to make sense of his own violent past, at times unsure of where it might seep into his present. When I asked him one of the standard interview questions, "Is there anything or anyone who has particularly helped you through this period of your life?", he answered, "I guess the doctor. I didn't know that what I was feeling was guilty. I didn't know that some of these feelings were normal, that others feel this way. I thought it was just me. I thought I was crazy. I thought I was dangerous. I locked away all my weapons and crap. It took me a long time to realize that's not what it is. I still have weapons discipline, responsibility, and I always had it. It was just clouded for a long time."

In the meantime, he was not the only one frightened by his own capacity for violence, and reassured to discover that – back at home – his actions remained under control. His wife had her own fears of what he might have become while away, and it took time to assuage those, as well. "I ended up telling her, 'I'm not going to be that person who climbs up on a tower and

starts shooting. I'm way too disciplined. There's no way that can happen."[10]

While Carlos expressed reservations about the ease with which he learned the pull the trigger, other veterans made a clearer distinction between what kinds of violence were and were not acceptable in a combat zone. One Iraq veteran, Kevin, said that he had tried to be "a tough Marine," but made it clear that "there's Marines and then there's killers. A lot of my friends were killers. I was a Marine."

"What's the difference?" I asked.

"A killer is someone who doesn't have a problem killing people, mostly so they don't get killed. Join the military to kill. Basically have license to kill if they have to. I joined because I felt it was my obligation. And if I had to do it - I had to put people down - so be it. A lot of the people I knew were straight out psychopaths. They were good guys, but they were psychopaths. I was never a psychopath. I was just a normal guy."

Having met a scant one or two individuals over the course of the study who were frighteningly glib about their violence – one of whom bragged about tossing Beanie Babies in front of Hummers on a convoy, a game whose object was to get Iraqi children to dash between the moving vehicles – I have my own understanding of the distinction Kevin was making. There are those who learn to kill as part of their obligation to the military. There are those who give all signs of enjoying it.

Saying this, however, requires a recognition that that the difference between Marines and psychopaths may look very different from the perspective of a non-combat zone. Were all

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[10] Carlos refers here to the 1966 clocktower shooting at the University of Texas at Austin, an event which occurred only an hour northeast of San Antonio and remains lodged in local memory. After stabbing his wife and mother to death, former Marine sharpshooter Charles Whitman climbed the campus' central clocktower and, over the course of a 90 minute standoff, shot and killed fourteen people.

of those involved in the Abu Ghraib scandal psychopaths? What about Haditha? What about the battle of Fallujah, that Tony's commanders were so convinced would go down in history? What is the difference between a hero who kills and a psychopath? What is the difference between a victory and an atrocity?

There are vast reams of philosophy and social science devoted to pursuing these questions, but here, on these pages, they matter most in observing how the violence of war may follow service members home. Such questions of morality and selfhood may pervade veterans' memories and struggles, left hanging in the uneasy space between trauma (*that which happened to me*) and violence (*that which I made happen*). And inevitably, these uncertainties became part of veterans' moral experience of PTSD. Some were overwhelmed by a crime they had committed overseas – I think of Jesse and the Iraqi child he believes he killed while on a convoy in Iraq – but most of those who described particular events emphasized context rather than regret. Chris spoke of his attack on the prisoner amidst a backdrop of witnessing torture by the Northern Alliance and being unable to assist in the aftermath of bombings. Carlos described killing prisoners as mortars fell and the riots continued. Even Eric described himself trying to retain his tough Marine exterior, his status as someone who might have to "put people down" but who was not a killer, in the middle of telling me how he fell apart after collecting the mangled pieces of his best friend's body, torn apart by an IED. In some unarticulated way, these men seemed to suggest their violence was inseparable from their suffering. And they asked for neither forgiveness nor sympathy.

Death Hands

However, as I have tried to make clear throughout this dissertation, it is not only what veterans bring home from war that matters – those regrets and fears and nightmares they may feel or not feel and express or not express in an endless variety of ways. It is also what they come home to. This is the theme we return to now, considering how violence may echo in the fears of those waiting at home.

In January of 2008, *The New York Times* featured an investigative article claiming to have "found 121 cases in which veterans of Iraq and Afghanistan committed a killing in this country, or were charged with one, after their return from war." The authors wrote that, "In many of those cases, combat trauma and the stress of deployment – along with alcohol abuse, family discord, and other attendant problems – appear to have set the stage for a tragedy that was part destruction, part self-destruction." The authors' language was dramatic; they called such killings "gut-wrenching postscripts to the war for the military men, their victims, and the communities."[11]

The article received considerable attention for its portrait of shattered veterans wreaking havoc and death upon the nation they once had served. One blogger for Iraq Veterans Against the War responded in a long diatribe entitled, "Does the New York Times Hate Veterans?"[12] A local reporter I spoke with, who has written frequently about PTSD among veterans, complained that the Times article was part of a larger vilification of PTSD by the media. She fumed that the media was taking a fraction of extreme cases and using them to exaggerate the problem, neglecting careful analysis of the actual rate of violence committed by

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[11] (Sontag & Alvarez, 2008)
[12] (Hogg, 2008)

those who have served in Iraq or Afghanistan. In other words, the *New York Times* article offered no information on homicide rates among a comparable group of non-veterans, providing no point of comparison for whether the 121 homicides found to have been committed by some 1.5 million veterans represented a relatively high rate of violence or a low one. Various attempts were made by veterans' groups to determine whether these numbers were comparable to the general U.S. population, and although the figures themselves differed, each of the groups concluded that the rate of killings committed by veterans was less than or equal to those committed by civilians.[13]

The Times article's authors had anticipated the tenor of such complaints; they wrote:

> Given that many veterans rebound successfully from their war experiences and some flourish as a result of them, veterans groups have long deplored the attention paid to the minority of soldiers who fail to readjust to civilian life.
> After World War I, the American Legion passed a resolution asking the press "to subordinate whatever slight news value there may be in playing up the ex-service member angle in stories of crime or offense against the peace." An article in the Veterans of Foreign Wars magazine in 2006 referred with disdain to the pervasive "wacko-vet myth," which, veterans say, makes it difficult for them to find jobs.

Nonetheless, the article concluded that the killings suggest "the profound depths to which some veterans have fallen, whether at the bottom of a downward spiral or in a sudden burst of violence." The implication was clear: these veterans were struggling, many with PTSD, and the outcome of such struggles could be deadly.[14]

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[13] (MAF, January 14, 2008; SAPB, 2008)

[14] The question of whether or not this portrayal was justified remained up for grabs. An earlier New York Post editorial had claimed that "That stereotype [of the Vietnam vet] was also a news-media lie to begin with," and that "The myth of the dysfunctional vet that began with Vietnam has been created and spread, in large measure, by groups bitterly opposed to all U.S. military action" (as quoted in Kolb, 2006). Amidst the debate that ensued, the central question remained: Was the *New York Times* article simply resurrecting the post-Vietnam "wacko-vet myth" in an effort to discredit the wars in Iraq and

Other media coverage of Iraq veterans fell in line with the *New York Times*, also linking PTSD with incidents of violence committed by OEF/OIF veterans. *The Economist* published an article in which it was claimed – without citing a source, as though this was knowledge that could be taken for granted – that the effects of PTSD "can range from temporary readjustment problems to suicide and murder, both of which have reached alarming levels among soldiers returning from duty."[15] One prominent case in point, a 2008 article in *The New Yorker*, told the story of Travis Twiggs, an active duty Marine who deployed five times to Iraq and Afghanistan before being diagnosed with PTSD.[16] Twiggs was treated for his symptoms, but with little success, and embarked on an escalating cycle of increasing alcohol use and isolation from his family and friends. He went AWOL after an unsuccessful transfer to a new work assignment, joining his brother – a civilian construction worker – on a cross-country drive. Their journey culminated in a tragic confrontation with law enforcement near the U.S.-Mexico border, during which Twiggs fatally shot first his brother, then himself. The author of the article, reporter William Finnegan, speculated that Twiggs may have thought he was in Iraq at the time, lulled into a PTSD flashback by the Southwestern desert landscape around him.[17]

Afghanistan? Or was this important coverage of the suffering experienced and inflicted by combat veterans?

[15] ("Take Heart: PTSD Sufferers Deserve a Medal," 2009)
[16] (Finnegan, 2008)
[17] (Sontag & Alvarez, 2008); A similar hypothesis of flashbacks resulting in violence was put forward in the earlier New York Times article. Responding to these interpretations of veterans' violence as resulting from PTSD-related flashbacks, I asked psychiatrists and psychologists at the PTSD clinic about flashbacks and received inconsistent responses. One psychologist insisted that flashbacks are an extremely rare symptom of PTSD, most likely associated with comorbid pathology like dissociative disorder or psychosis; however, he also indicated that not all of his colleagues are in agreement with him on this point. This lack of consensus among clinicians can create difficulties in determining appropriate treatment for those who report having flashbacks (i.e. actively *reliving* an event) as opposed to vivid memories of a past event.

These media representations of PTSD-related violence are important in that they both reflect and inform broader American concerns about the potential threat posed by the warriors in our midst. These articles would not have gained the attention they did had they not resonated with an underlying concern about service members, some lingering doubt about the consequences of teaching men to kill and then sending them off to do it.

At times, this fear rises close enough to the surface to have a ripple effect for veterans making the effort to move ahead with civilian life, reverberations brought to light by a clinical psychologist who provides counseling services at one of San Antonio's colleges, where the student population contains a large and growing number of recent veterans. Our conversation took place a few months after the tragic April 2007 shootings at Virginia Tech, in which 33 people were killed by a young man with no history of military service. The psychologist, Dr. Lewis, described a subsequent university committee meeting at which doubt was expressed as to the potential instability of Iraq veterans, among others on campus. A list of 'individuals to watch' was drawn up, and Dr. Lewis was appalled to see how many of those on the list presented no apparent risk other than being veterans who were considered by their professors to be 'quiet' or 'odd' (she mentioned one young man, a non-veteran, who was known for bathing infrequently and walking around barefoot). When she questioned the reasons for adding veterans to the list, another member of the committee spoke up to remind her that, as former military personnel, these men were trained to kill. Dr. Lewis, furious, informed the

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However, the likelihood that an individual such as Twiggs would have been swayed into such extreme violence by his desert surroundings seems, from a clinical perspective, rather slim.

committee that she was herself a veteran and therefore, by implication, dangerous. She held up her hands, and said, waving them dramatically at her colleagues, 'These are death hands!'

In Dr. Lewis' story, violence committed by a mentally ill student at Virginia Tech became fuel for local fears about warriors-*qua*-students. At the time, I wondered to what degree Dr. Lewis was describing an isolated incident, given the many ways in which San Antonio residents make a clear effort to show their support for veterans. But over time, other stories emerged as well. A nurse at the VA told me that her daughter and son-in-law, an active duty soldier, had gone to visit their priest to have a blessing placed upon their marriage prior to the son-in-law's deployment to Iraq. While they were at the church, a man claiming to be an Iraq veteran came in with his wife asking for help. He wasn't a parishioner, and so he was told that they could give him food or clothing, but no financial assistance. The nurse's daughter reported that the clerk he spoke with – evidently the priest was inside his office, listening to the conversation – handled the man gently. She tried to get him to fill out some paperwork requesting further assistance, but the man became furious and started throwing papers around and ranting that no one would help him. Eventually, the man gave up and went outside to calm himself back down, but the priest, unaware of what such an enraged veteran might do, had already fled out the back of the church.

Many of the veterans had heard such stories, or had their own versions, which they put forward as cautionary tales of what trouble can come to troubled veterans. Manny was talking one day about his friends still overseas, and said, "They got nothing left. And in the end they come back home and what problems are they going to cause in the United States? There's already been – I know we had one guy heard a car backfire and he jumps on the median and takes off. And the cops are like, 'What's this guy doing on the median?' I think he gets out of

the car and sees their guns, pulls his gun out of the car and, thinking he's in Iraq, he gets into a shoot-out until his wife tackles him or something. Because his family was in the car. And he didn't know. They're going to come back with problems. Everybody in this country is going to be affected by it too now."

I do not know the origin of this story, whether the man involved was a friend of Manny's or whether this was something he had heard on the news. Nor can we know, based on the nurse's secondhand tale, what the priest was afraid of. Was it the man's rage? Was it the fact that he was a veteran? Was the priest not afraid at all, just taking a quick jog around the church between meetings? There is no way to tell. But the accumulation of these stories gives added resonance to comments already heard from veterans themselves. Jesse said of his girlfriend, "She thinks I'm going to get scared and try to kill her or something. A lot of people have that idea, honestly." Carlos felt the need to tell his wife, "I'm not going to be that person who climbs up on a tower and starts shooting." Manny said that he didn't like to tell people he has PTSD because "people will think I'm going to go crazy and shoot everything up."

Individual veterans may or may not have violent tendencies or mental illness, but – fueled in part by media representations of PTSD – they remain linked with violence in the public imagination.

For those who are sensitive to this link, it can create another layer of distress or uncertainty. I asked Jesse about what his girlfriend had said, and he described the interaction in more detail. "She told me that when we first started talking. 'You're not going to kill me, are you?'" When he reacted incredulously, she said, "'Oh, I'm just playing.'" But he was left perplexed. "Why would you say that? I think that's everyone's perception, really, that you're going to start tripping out, flipping out. It's like, wow. It's awkward."

"Well, what do you say to that?" I asked.

"What the hell's wrong with you? No, but…I get pissed! Why would you say that? I guess it's just…" his voice trailed off.

"Do you ever worry about that?"

He paused before replying. "Sometimes I worry I'm going to lose control," he said. "I'm going to break down or pass out or some shit. I usually do that because I get headaches." And he began talking about his headaches, his emotions. His fears of breaking down seemed to be less about violence and more about the embarrassment of having to walk away from watching movies with his friends because he couldn't hide the tears in his eyes, couldn't conceal the panicked breaths he was beginning to take.

But for some, this fear-tinged, quasi-expectation of violence became yet another obstacle in their struggle to perform as civilians after years of military life. The second time I met Tony, he described a recent run-in with his girlfriend's family after he physically restrained an uncle whose behavior had gotten out of hand at a party. He recounted how the conflict escalated to the point where he felt it necessary to take the highly intoxicated uncle down using a controlled headlock, which he demonstrated step-by-step there in my office. He hadn't hurt the uncle, he insisted, he just temporarily restrained him. A police officer in the family told Tony that he handled the situation just right, just like a cop would. But his girlfriend and the other women at the party had been very upset. What he saw as a highly disciplined maneuver, they saw as violence. He was certain that he had been right to do things as he had, but not so certain that he didn't seem to be asking for my reassurance in repeating the story. "I didn't do anything severe. I just – I restrained him. Textbook. And to me, it doesn't look like – well it is. It's very violent, it's very fast and that's it. I could have easily made him pass out or whatever, but all I

did was restrain him. And everybody else made me out to be the bad guy afterwards. I was like, 'Your uncle was getting out of hand. If he doesn't know how to control his alcohol and you all don't know how to control him, then I'm going to control him.' And I did. He was fine. He apologized the next day."

Later on, I remembered how Tony had spoken of his father's violence and wondered whether perhaps that was part of whatever nagging discomfort drove him to talk at length about his reasons for acting as he did. Given his pride in his family, his love of his nieces and sisters, his disgust for his father, I do not believe that Tony wanted to think of himself – as the women at the party seemed to think of him – as a violent man.

Intimate Violence

In 2007, I attended a screening and discussion of an unfinished film about veterans in San Antonio. In one scene, a young Latino man was shown painting a mural on the side of a building in the downtown area. The mural depicted soldiers in full Vietnam-era Army gear crossing a field with a row of trees behind them, under the words, "You are not forgotten!" Along the bottom of the wall, a line of black combat boots had been painted in. Tiny differences in the size, leather, and wear of each pair suggested the individual men who might have worn them; their emptiness referred hauntingly to those lost in the conflict. In the film, the young man sat on the scaffolding and talked to the camera and to his father, who was standing beside him, about the fact that the father was a Vietnam veteran. He talked about how, six years before, he had nearly written off his father entirely, but said that he has since learned to understand him better. He said the mural was, for him, a testament to his father's experience in

Vietnam and the impact it has had on his life. It is a simple scene, unpretentious and matter-of-fact, but powerful for all that.

In the discussion that took place after the film, a tall Latina with black hair piled in a bun on top of her head asked about this scene with the mural, and suggested the director should leave out this scene because, she said, it glorifies war. The director seemed surprised by this idea, and leaned back in her chair as she asked, 'Does it?' The tall woman said, 'Absolutely!' and nodded vehemently, while a small grey-haired woman in the next chair signaled her agreement. The director said, 'No, I don't think it does. I wanted to include that scene because it's about [the father and son], not about the mural. But the mural doesn't glorify the war, it says we haven't *forgotten*. It says thank you for your service.'

The tall woman rejected this answer, raising her voice and beginning to wave her right hand around. 'The *barrio* boys see that mural and it's not as if they don't see enough honoring of warriors as it is. But,' she said, 'we women know what war does,' and here she pushed at the air with a fist in rhythm to her words, '… the men come home and *beat* their kids, *beat* their wives.'

The room fell silent. I wondered what the veterans sitting around me were thinking, what was going through the mind of the man across from me, who I knew to be a Vietnam veteran and who sat leaning back in his chair with his arms folded across his chest, saying nothing. There continued some back and forth between the tall woman and the director. Another woman spoke up, offering a more moderate position. 'Many people don't like the mural. It does seem to glorify the war, and for those in the community who are against war…' Her voice trailed off.

The director spoke up again: 'But it's not about glorifying anything…that was what these men *experienced*. This was what they lived through, and I, personally,' she pressed her hand to her chest, '*value* that service. I feel that they should be thanked for their service.' The tall woman exploded. 'Thanked for *what*?!' she shouted, waving her arm so violently that I thought for a moment the precarious bun on top of her head would slip to one side. 'Thanked for coming home and beating up their families?' The room fell silent. She then spoke of her own experience with her veteran father, and her vehemence began to come into focus.

Sadly, violence among veterans of Iraq and Afghanistan – as attested by the New York Times article and perhaps by Tony's story as well – is not only a matter of suspicions and fears handed down from the aftermath of previous wars. One of the first scandals to arise from the war came in the summer of 2002, when four women were killed in the space of a few weeks by male soldiers at Ft. Bragg, three of whom had recently returned from combat deployments to Afghanistan.[18]

The evidence suggests that that the vast majority of service members or veterans never commit violence within their families or relationships. I have seen soldiers up in arms at the idea of anyone hurting a woman or child. It is true, however, that rates of Intimate Partner Violence (IPV) are consistently found to be higher among active duty military personnel than among demographically matched civilian populations.[19] Among veterans, PTSD seems to stand out as a predictor of IPV. The National Vietnam Veterans Readjustment study found that 33% of veterans with PTSD reported having perpetuated IPV in the previous year, while only 13.5% of

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[18] (Starr, 2002)
[19] (A. D. Marshall, et al., 2005)

veterans without PTSD made such a report.[20] Among World War II veterans who were prisoners of war, as well as more recent veterans with other severe mental illness, current PTSD has also been found to be a predictor of violent behavior.[21]

When I began this study, I was already interested in issues of IPV, having worked previously in this area. I made a decision early on, however, that I was not going to ask veterans about partner violence. I was already at risk of taking on too many issues at once, in interviews that averaged close to three hours long, and I knew that IPV was not a topic to be taken on quickly or superficially.

But although I did not ask, and therefore cannot cite reliable rates of violence among men in the study, IPV had a way of coming up. Before I began the study, I found that people often met descriptions of my plans with questions about the place of PTSD in family violence, sometimes volunteering admissions of violence committed by family members who were veterans. This happened more often than I would have predicted. Once begun, the study followed this trend.

What becomes clear in examining the stories of IPV that emerged, however, is that PTSD-diagnosed veterans and their partners described patterns of violence that may be quite different from those more widely documented in the existing literature on IPV.[22] Participants in the study described three relatively distinct patterns of violence, each with a unique understood relationship to PTSD symptoms and – importantly, for understanding the moral elements of felt

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[20] (B. K. Jordan, et al., 1992)
[21] (Elbogen, Beckham, Butterfield, Swartz, & Swanson, 2008a; O'Donnell, Cook, Thompson, Riley, & Neria, 2006); In addition, PTSD related to combat as opposed to other traumas also appears to increase the risk of partner violence (Prigerson, Maciejewski, & Rosenheck, 2001).
[22] (Holtzworth-Muroe & Stuart, 1994; M. P. Johnson, 1995; Pence & Paymar, 1993; Walker, 1980)

and perceived culpability among veterans – different associations for veterans and their partners as to the amount of control veterans could exert over such violence.

The first type of violence described – *violence occurring in moments of anger*, or as an effort to exert control over the intimate partner – is perhaps most consistent with broader understandings of IPV.[23] Often when domestic violence is discussed in the U.S., the perpetrator is described as a brutal tyrant whose violence is mal-intentioned and likely to escalate; domestic violence has even been defined as "a pattern of coercive control consisting of physical, sexual, and/or psychological assault," a characterization not wholly inconsistent with descriptions of IPV in the PDS study. [24] One veteran in the study, who was *not* diagnosed with PTSD, narrated acts of violence against the women in his life with what can only be described as exhilaration, and wondered aloud whether there might be something wrong with him because he felt no remorse.

But he was the exception. Most often, the stories that emerged were far more nuanced, tinged with shame and hope for change, although no less frightening for the dangers they revealed. These stories often bore some resemblance to what I heard from Maria Franklin, whose husband brought her the study flier and suggested that she might want to talk to me. When we first spoke on the phone, she told me only that her husband was an Iraq veteran with PTSD, and that they had faced some post-deployment challenges, just as my flier described.

When I drove down to their house to meet with her, I found a youngish man out in front, laying a brick border around an overgrown rose bush. He was stooped over arranging the bricks and didn't turn around until I was most of the way up the driveway. Then he swiveled,

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[23] (Bitler, Linnoila, & George, 1994; Sisley, Jacobs, Poole, Campbell, & Esposito, 1999)
[24] (Flitcraft, Hadley, & Hendricks-Matthews, 1992, as quoted in Sisley et al. 1999)

said hello without making eye contact, and beckoned me to follow him. I did, saying to his back, 'I'm Erin.' He said, 'I'm Andy,' and 'Maria's in here.' He was short and slim, built heavily through the shoulders, with cropped blond hair and a narrow pale face. He knocked on the front door, which featured worn stickers reading "Proud to be an American" and "Support the Troops". Hung between them was a plaque displaying the Liberty Bell, an American flag, and the head of a Bald Eagle.

After a moment, he realized what he was doing, and said, 'What am I knocking on my own front door for?' before pushing it open. Maria was there just inside, petite and pregnant, with grown out highlights and fashionable black frames on her glasses. Andy went back outside and Maria offered me a seat on a loveseat just inside the door. The house was low and dark inside, windows heavily covered in vertical blinds, and it took my eyes a minute to adjust to the darkness after the morning sun outside. The living room area was very clean, crowded with an oversized olive green chair, sofa, and loveseat all set facing one another in front of a small TV. Beyond were white walls, the entrance to a kitchen/dining room area, and several white doors, one with a large brown dent punched in it. She pointed to it later when she described how reckless Andy had become.

Maria, now 26, met Andy when she was a senior in high school. She came from a difficult home – her father was in prison throughout her childhood and her mother worked overtime to support her four children – and had her first child when she was 16. She managed to stay in school and care for the baby until her final year, when she was suspended for absenteeism because she kept missing the bus. A woman at the school, Andy's mother, offered to transport her to school until she completed her diploma, and so she and her toddler son moved into the Franklin's house.

Andy was already in the Army then, serving at Ft. Hood, so they didn't meet until he come home for a month's leave prior to a year in Korea. They hit it off right away, and were engaged before he left. She said, 'And ever since then we've made a life together.'

But it wasn't easy. He was in Korea for a year, and then back only 6 months before he left for Iraq. Their first child together was born during time between deployments, and they married immediately afterwards. When he left for Iraq, she was still living with his family, but she insisted it was time to move on. So while he was deployed, she bought their house and all the furniture and settled herself and the two boys in. She had trouble finding a mortgage company who would honor her power of attorney while he was gone.

When Andy returned home, it didn't get any easier. He moved over to the National Guard and got a job working at a local prison, but she said that she still doesn't feel like he's entirely come back. He had lost soldiers from his platoon, his anger was out of control, and – for the first time – he was violent with her. The violence escalated in a discernible pattern. He would get angry and become verbally or physically abusive. She called 911 several times, but she said that he was trained in knowing how to cause the most pain with the least visible injury, and the cops, when they arrived, dismissed her claims that he had assaulted her. In 2006, she attacked him and was herself charged with assault. She was furious and ashamed that her violence was punished while his was not. But she said that he had not raised a hand against her in the intervening two years, although he was still verbally abusive and prone to destroying property when he was upset. She pointed to their bedroom door, cracked and dented at shoulder height. She said that he had been diagnosed with PTSD, that they were getting treatment.

I asked her if she felt safe telling me all this, knowing that Andy was just outside. She reminded me that it was his idea that she talk with me, that he had given her the flier. I thought of how he greeted me without eye contact, and how he knocked on his own front door while ushering me into the house. Perhaps he was ashamed. Perhaps he wanted to give her the opportunity to be believed.

Given how frequently anger is cited as being central to experiences of PTSD, it is unsurprising that anger and violence should be linked among veterans with PTSD. Even PDS study veterans who gave no indication of having experience with partner violence were aware of their own potential for aggression, and often concerned by it. Men in the groups sometimes spoke about finding themselves arguing with their wives and having to leave the house before they did 'something stupid.' Tony described his own worries about this. "I can control myself and I'm fine," he said, "But I don't think I've been pushed, and I don't want to be pushed… I know what I can do, because…one of my jobs in the Marine Corps was to be a close-combat instructor. And I trained Marines to fight, and I was a black belt instructor. So I worry, because I know my limits and I know what I can do, even though I don't do it every day." His girlfriend, he said, "she doesn't understand that. I just want people to leave me alone sometimes. When I say leave me alone, please leave me alone. She won't leave me alone, she just gets in my face. So yeah, it worries me. Like, wow."

Cary and his wife, Melissa, separately described the second mode of violence: *violence associated with blackouts or other dissociative episodes.* During our first meeting, Cary was in the middle of explaining how he had come to the VA seeking treatment for his PTSD when he suddenly paused and then said: "I hit my wife bad. I have no recollection of it. That wasn't the first time it happened. It happened…frequently I would sleep on the couch. I would never sleep

in the same room with my daughter or my wife. The medications I'm on now have taken care of that, but it took until I got arrested, and when I got arrested I called [the VA] and told them what was [going on]. I got arrested for something I don't even remember doing."

After talking with his psychiatrist, he was told that the episodes were related to something like sleep-walking. "Which is weird because he told me that, and I'd never told him that my wife said that my eyes would be open when I'd be doing this. And the only way that she'd know that I was asleep was I'd lay back down and close my eyes. And so it's embarrassing – it's horrible for her, it's horrible for me. I've got to wake up and see this and go, 'Oh my God, what happened?' She's like, 'You did this to me.'"

I interviewed Cary's wife in their apartment a few days later, and she showed me pictures of the two of them when he came home from the first of two tours in Iraq. In contrast to the man I had met – stoop-shouldered, skin slightly grey – this Cary looked like a different man, standing in the center of the photo looking bronzed and handsome, with his father on the left and Melissa on the right, holding onto his arm. In the photo, she had long curly hair.

When we met in the apartment, her hair was straight and fell awkwardly to her cheekbones. She said that Cary used to pull her hair when he was chasing her, grabbing it to keep her from getting away, so one night she took out the razor and shaved it all off. She traced fingers across her face where she said her nose had been broken three times, her cheekbone crushed in, her skull fractured.

She said that after the first deployment, he would "pace the house at night. I'd ask him, 'what the fuck are you doing,' and I would catch him off guard and he'd start choking me. One time, I was having a hard time hearing him, because he was talking while he was choking me, but I knew he wasn't talking to me. Because I wasn't a guy, and I wasn't Iranian or whatever the

hell he was talking about. And then all of a sudden, just out of nowhere, you see him do *this*…" and she mimed eyes opening wide and awareness dawning upon his face. "Like he had just snapped back into reality. Like people when they drink and they pass out and then they wake up. It was like that with him, only he hadn't been drinking, he was sleeping! And I had bruises all over my body."

That was after the first tour, and after the second tour, she said, was even worse. "I mean, he could be in the kitchen and I'd bump into him and he'd start pounding me in the head, following me around, and he would have no memory of it. It was the weirdest thing because I didn't understand at that time that he was sleep-walking. I didn't even see him go to sleep. Apparently, he was…one time he woke up and I had a broken nose, my cheekbones were all bruised up, I had two black eyes, and my forehead was all one big bruise. He woke up and goes, 'What the hell happened to you?' I said, '*You* did!' 'Oh, that's it,' he says, 'I'm sleeping on the couch from now on. If you see me walking around the fricking house, don't talk to me. Leave me there alone. Put a chair up against the door and put the baby in the room with you.' Well, that's what we did for about a year and a half."

"Did it work?" I asked.

"Well, unless I walked into him if I didn't know he fell asleep during the day. But you know, for some reason the baby could walk right by him and 'Daddy Daddy Daddy!' Maybe she was unthreatening because she was so little. He never flared up around the baby."

This was before they put him on the anti-psychotic medication Seroquel, commonly prescribed to help with sleep and nightmares. Cary says that the medication has become essential. "I feel like I have to have it. It's a ritual. It's very important. God forbid the baby comes over and wakes me up without me taking my medication. That had me so scared for so

long." Melissa says that, now "every once in a while he'll swing in his sleep and like butt my head, but that's just him restlessly sleeping. And you'll hear him yelling out coordinates and shit. And you'll go, 'Oh, he's in Iraq, the pills aren't working. I'm going to sleep on the couch.'"

She blames the violence on Cary's PTSD, for which he is rated 30% disabled and receives compensation. "But," she said, "I think he's dissociative too, because he doesn't have any recollection of some of the things he does when he's dissociative." She's not always sure whether he has fallen asleep "as much as he's, like, switched."

She is passionate in describing the consequences of his violence on her, on their relationship, on their lives.

"I've seen the difference between the man I married, the man I live with, the man I sent to war, and the man that came back. Totally different. The war has ruined our lives. And I've wanted to kill him. I've almost divorced him three times. Because he doesn't ever remember [the violence] and that makes it worse. Because if you don't even remember you're doing it, how can you stop?" Meanwhile, she has also been diagnosed with PTSD. She says, "I'm starting to be like him. So I beat him up once. And apparently the cops said I was screaming, 'If you ever hit me again I'll kill you next time, you little motherfucker.' So we both have a case pending. I'm getting off on Battered Wife Syndrome. He's probably going to get off on PTSD. Our lives are a mess from this."

Toward the end of the interview, I asked Melissa why she had stayed with Cary. She said, "Because I love him and I knew this wasn't him and I was always hoping that he would get help and I didn't want to abandon him because I was afraid of what might happen to him if [I] took off. And then he'd be all alone, and he fought for his country and now he lost his sanity and his family. And I knew he'd want to kill himself. I mean if he was in perfect health AND he

was doing this crap? Oh, he could jump off the side of a cliff. I'd push him, if he wanted me to. But it's not him. It's not him."

Cary and Melissa's description of his episodes as "sleep-walking" or "dissociating" resonate with the kind of descriptions found in media accounts – the veteran inexplicably reacting to a non-threatening environment as though under attack, appearing to inhabit the classic flashback. There were similar experiences among other veterans in this study, although only rarely, and they invariably left the veterans involved with what they described as a sense of confusion and fear. Jose had not had an episode like this in months, but remembered that "I'd get so mad, and the next thing I know my wife's crying. Or I'm crying. Or something's broken. It was really really scary. Those were really scary. Because for me to have blackouts like that – what's to say I might not really hurt my wife? Really hurt my daughter? It's really scary. Just kind of you don't trust yourself anymore."

These, then, were the first two types of IPV – violence of anger and violence of dissociation. The final pattern described in the study was the kind that Chris spoke of, throwing his wife across the room because she climbed over him while he was sleeping, waking up to find himself with his hands at her throat. This was the most common type of violence veterans discussed – *violence occurring during sleep, or parasomniac violence*[25] – and it came up regularly in group therapy accounts, interviews, and second-hand stories. One of the group members described waking up on his front lawn holding a baseball bat, somehow having made it out of bed and down the steps without his prosthetic leg, his wife screaming, 'What are you *doing*?'

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[25] Parasomniac violence is an area of relative quiet in the research literature (Lam, Fong, Ho, Yu, & Wing, 2008; Mahowald, Bundlie, Hurwitz, & Schenck, 1990). I have come across only a few studies examining hyperarousal during sleep in PTSD (Belleville, Guay, & Marchand, 2009; Kramer & Kinney, 2003; Sheikh, Woodward, & Leskin, 2003).

Another spoke of sleeping in the guest room after waking up one night flailing in bed with his wife and child, coming to and realizing that he had nearly smacked his little girl.

I have taken some time to characterize each of these rough patterns of violence because each is associated with a distinct set of PTSD symptoms. The stories suggest that these symptoms of amplified anger, dissociation or flashback, and sleep disturbance are each linked with a distinct pattern of violence committed by veterans within the home. On the applied level, recognizing the distinctions between these three patterns of violence opens up the opportunity to further investigate the course of IPV among PTSD-diagnosed veterans, and to find new ways to support families encountering such violence. It may be appropriate, for example, to recommend coping strategies that are tailored to a particular type of violence. For example, sleeping in separate rooms may be sufficient protection for family members of a veteran experiencing sleep-related violence, but may be inadequate to provide real safety for the spouse and children of a veteran engaging in dissociative or anger violence.

Toward the goal of better understanding veterans' experiences of PTSD, however, this typology of violence is also useful for clarifying how each of these kinds of violence elicited responses from veterans themselves, who described varying degrees of helplessness in the face of their own potential aggression. Veterans who feared their own anger – as many of these veterans did – spoke of taking steps to prevent violence, both within the home and outside of it, by avoiding confrontations, walking away if a conversation got overly heated, leaving the house before they did 'something stupid.' Although it is unclear how representative these veterans may be, and how much violence may have actually been taking place, a substantial number of veterans did describe taking active measures to practice anger management and avoid violence.

For veterans like Cary and Chris, whose outbursts seemed to occur during either sleep, periods of dissociation, or in some nebulous ground in between (Cary's "sleep-walking"), there was a much greater sense of violence as something frighteningly beyond their personal control. Still, the degree of helplessness varied. Chris, like other veterans who had erupted during sleep, could take steps to sleep away from his wife and children. Cary, on the other hand, because his dissociative periods happened at times during the day, felt as though all he could do was to take his medication and order his wife to bar the door if necessary. In the meantime, *his* violence had spiraled into *their* violence, with both he and Melissa facing charges for battery. His PTSD had, too, become her PTSD.

The type of violence had consequences for veterans' partners as well, most importantly in the decisions that spouses made to stay in the relationship or to leave it. Wives often seemed to suggest that violence understood as PTSD-related was not always subject to the same rules that might apply to other forms of IPV. Melissa was explicit on this point, saying repeatedly that she would have left Cary if she thought his brutality was intentional, but that "it's not him." In this way, wives and veterans' own loose typologies – what violence was the result of PTSD and therefore involuntary vs. what was volitional and therefore inexcusable – offered one way of managing the issues of culpability, of blame and responsibility. This left grounds for negotiation, for sorting out a response. One clinician I spoke with was hesitant to link PTSD with violence at all; he said that in his experience, there was unlikely to be intimate violence after deployment unless there was violence *before* deployment.[26] Certainly, in group sessions, the psychologist

[26] Some support for this theory is suggested by the results of McCarroll et al. (2003), which found that the most significant predictors of partner violence following a *non-combat* deployment were nonwhite race, being relatively younger, living off-post, and having a history of predeployment violence. Among those

Dr. Adams was careful to point out that PTSD was no excuse for violence. Yet I heard the polar opposite from a veteran's wife who insisted that, while a veteran with PTSD may give his wife a black eye, "It's not the same as domestic violence. It's really not because a lot of times these guys really don't realize they're doing it. Where with domestic violence they know they're knocking the crap out of you." This was how she distinguished between the violence committed against a woman in her family (in response to which she said she would gladly get out her husband's gun) from the violence she hinted went on in the household of one of her husband's veteran friends. There's PTSD, she seemed to be saying, and then there's violence. Her model of PTSD, like Melissa's, gave rise to a complex tangle of attributions: the illness might lead to violence, but it also made that violence forgivable.

This whole discussion is made more complex by the fact that, from a clinical perspective, this notion of dissociative violence is controversial, to say the least. Although violent flashbacks and other dissociative episodes are *popularly* understood to be a feature of PTSD – as seen in media accounts and in the stories told here – the research literature suggests that PTSD-related dissociation is not a convincing explanation for this kind of violence. A pre-existing tendency to dissociate does appear to be a risk factor for developing PTSD after trauma exposure, as does experiencing dissociation at the time of the trauma.[27] In other words, dissociation appears to be less a result of PTSD than a trait or susceptibility that makes one more vulnerable to it.

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who reported previous violence, the odds ratio for violence in the first 3 months after a deployment rose to 4.56.

[27] Tendency to dissociate, in fact, appears to be more predictive of developing PTSD among veterans than does the amount of combat exposure (Marmar, et al., 1994). Several studies have also shown that a sub-group of those with PTSD demonstrate elevated symptoms of dissociation (Kaufman, et al., 2002; Roca, Hart, Kimbrell, & Freeman, 2006; Waelde, Silvern, & Fairbank, 2005).

Moreover, the links between dissociation and violence remain vague and understudied.[28] One study conducted among adolescents in inpatient psychiatry care found that those who with a history of committing violence were more likely that their non-violent coevals to demonstrate symptoms of PTSD and dissociation. However, these individuals were also more likely to have a history of childhood abuse, which predicts PTSD and dissociation, making it impossible to tell whether they were more violent because they were dissociating or because they had been exposed to the kind of violence that predicts dissociation.[29] Another study examining symptoms of psychosis among veterans with PTSD found that 17% of those in the study had experienced at least one psychotic symptom.[30] In all but one of these cases, however, these hallucinations were auditory. Even among those PTSD-diagnosed veterans with full-fledged hallucinations, the hallucination was most likely to consist of re-experiencing something like the shrieks of a friend killed in combat, not the sudden violent conviction that your wife is an attacking Iraqi insurgent.[31] In fact, an archival study of PTSD-diagnosed British veterans across history found that dissociative flashbacks were not commonly reported until recent decades; the authors suggested that flashbacks may, in fact, be a culturally-specific symptom of PTSD, not inherent to the disorder at all.[32]

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[28] (Moskowitz, 2004)
[29] (Fehon, Grilo, & Lipschitz, 2005)
[30] (David, Kutcher, Jackson, & Mellman, 1999)
[31] There is evidence for elevated violence and paranoia among veterans with comorbid diagnoses of PTSD and a psychotic disorder such as schizophrenia or depression with psychotic features (Sautter, et al., 1999).
[32] (Jones, et al., 2003)

The message here is that, while experiences of dissociation may well accompany PTSD for a subgroup of veterans, there is no evidence to support the idea that intimate violence can be explained away by such dissociation.

Returning to the larger discussion, I have no intention of suggesting intimate violence is a problem among most veterans; there is no evidence to support such an idea, nor do I believe it to be true. On the contrary, one of the central goals of this dissertation has been to point out how multi-faceted is the manhood lived out by these veterans – in their tenderness, their love and compassion, their fears, suffering, and nurturance. Nonetheless, IPV was described by a handful of veterans in the study, and was implicated as a fear by a larger group. As with compensation-seeking and morally uncertain violence committed in Iraq or Afghanistan, veterans seemed to recognize IPV as a cautionary tale, perhaps more or less likely to be part of their own experience, but an acknowledged if rarely spoken-of possibility. For veterans whose PTSD left them drifting on the outskirts of the personal control they were used to, the notion of hurting one's loved ones could present a frightening vision, or a terrifying reality.

"Oh my God, what happened?"

"'You did this to me.'"

To accept that violence may be frightening for the perpetrator as well as for the victim does not unknot the snarl of PTSD, intimate violence, and the very real consequences of that violence for those who bear its brunt. One of the Vietnam era spouses who participated in the study, Cecilia, told of how she had finally left her husband after four years in which she had learned that if he awoke her in the night, it was time to run. If she didn't run fast enough or far enough, he would come hunting her with all the skills, she said, of a man who has lived through night combat in the jungle. So many years later, Cecilia still retains the imprint of those nights.

She requires her distance from others. She cannot sleep too close to her boyfriend and wakes immediately if he touches her. She sleeps only in absolute dark and wakes at any small noise. About six months before we spoke, her ex-husband had called out of the blue – fifteen years after she left him for the last time – to say that as much as he still loved her, she had been right to leave. "'I would have killed you,'" he told her, "'then I would have killed myself.'"

Points on a Compass

In this chapter, I have attempted to offer a richer appreciation for how America's cultural ambivalence towards its veterans may play a role in shaping the moral experience of PTSD. Veterans with PTSD are not unique in finding themselves in a position to make life choices in relation to external images of who they are and what they do – this is of a piece with the moral realities of living in culture and amidst society. We may exist as individual selves, but we navigate the practice of that selfhood via the bright or murky fog-lights of the world around us. So, too, veterans with PTSD must find their way within the ambivalent permutations of what combat PTSD is understood to mean in contemporary America: its association with both the honor of service and the disgraces of failure and weakness, with gratitude for sacrifice and the fear of violence that might not stay within the boundaries of the combat zone.

The stories above reveal three focal points for ambivalence in the lives of recent veterans struggling with PTSD. There is, first, the ambivalence that many veterans of Iraq and Afghanistan feel towards those veterans who have come before: the respect that many have for older veterans existing side by side with the desire to avoid too much association with Vietnam era veterans and their burden of stigmatized identity. For veterans of Iraq and Afghanistan, the most important points of navigation may be marked by other veterans, whether those role

models who were an inspiration for joining the military, those heroic peers and leaders who provided a motivating example during their years in the service, or those veterans they find they *do not* want to emulate. These available moral examples, positive and negative, are embodied in those with whom veterans have met and interacted, in the cautionary tales heard from others, and/or in the wider cultural stereotypes that permeate media portrayals and the conversations and judgments of everyday life. How veterans view those who have served in previous conflicts, as well as their fears related to what may be happening in their own lives and illness (violence, helplessness, becoming the guy in the hat), may become an important influence on practical choices like where and when to seek care and apply for compensation.

The second point of ambivalence is that tension to be seen in how contemporary American society both exalts and fears its combat veterans, praising them loudly as heroes while – in some more circumspect, *sotto* voiced way – fearing what taint of violence they may have brought home from the wars. There does not appear to be evidence that veterans in general are more violent than other men. There does appear to be some evidence that veterans with PTSD are more likely to engage in violence than are other veterans, although probably not to the extent suggested in media portrayals. This in no way means that such violence is inevitably a part of PTSD, although where a relationship between PTSD and violence is understood to exist it may create additional concern for veterans and those around them. Far more often than stories of violence itself, I heard stories of veterans' *fear* of violence, of their concern that it might migrate unwelcome from their past into their present. The shadowy threat of uncontrolled aggression became a reason to exercise self-discipline, to take medication, to know when to walk away. This was not always enough to quell the fear. As Tony said, "I can control myself and I'm fine. But I don't think I've been pushed, and I don't want to be pushed."

Where violence did occur, it was likely to be interpreted within veterans' and victims' own explanatory models of PTSD and violence, which themselves seemed to point towards a third area of ambivalence. If the violence was understood to be part of PTSD and therefore involuntary (as in the case of violence committed during sleep or a dissociative period) or as otherwise excusable ("It's not the same as domestic violence"), then certain judgments normally placed on those who commit violence might be tempered, the veteran left baffled and frightened but able to excuse himself, to be excused by others. Depending on the type of violence, the veteran might choose among a selection of responses: sleeping away from family members, seeking out treatment, and so forth. For those who heard of the event(s), it might pass into yet another cautionary tale, to be re-interpreted again by new listeners, perhaps in line with other explanatory models. And so even among veterans who were not currently violent (but who once had been, in their combat lives), the violence of other veterans could serve as a powerful warning, a rumble of distant thunder. Meanwhile, within the families for whom IPV was a reality, the very PTSD that was blamed for bringing violence into the home could also make that violence permissible, creating perhaps the most heart-wrenching ambivalence of them all.

It is important to note that, among the 19 spouses or other partners who participated in this study, only one was no longer in the relationship with the veteran; this was a group made up almost entirely of women who had stayed with their partners even though the relationship might be struggling. The attitudes towards IPV expressed by women in this group, therefore, may not be representative of other partners' experiences of PTSD and physical abuse. There was only Cecilia's story of leaving, and only her voice to say that it did not matter how much she

loved her ex-husband or wanted to excuse him or pitied his suffering, that she fled the relationship fearing for her life.

Amidst all these struggles of living in relation to both perception and reality, many of the veterans in this study can be seen as fighting off a spoiled identity. They did so in small and large ways – by considering where to seek care, how to identify themselves as veterans or not in the clothes that they wore, by choosing one or another response to the problems of PTSD. Not only were they haunted by the stigma of PTSD as a sign of mental weakness, but by also its residual contagion of other failures in life and war, of crazy Vietnam veterans, of other generations and other veterans who had brought their combat home. Arthur Kleinman has written of stigma that it often carries "a religious significance – the afflicted person is viewed as sinful or evil – or a moral connotation of weakness and dishonor. Thus, the stigmatized person is defined as an alien other, upon whose persona are projected the attributes the group regards as opposite to the ones it values."[33] For those, like Tony and Jesse, who feared some loss of control, these negative projections could serve to mirror and amplify their own.

Many of the men in this study, in our discussions of their early decisions to join the military, described growing up with the idea of combat veterans as heroes, men worthy of respect and admiration. Thinking of this, it is easy to understand veterans' often overlapping experiences of anger, bafflement, and despair upon coming back from war to find themselves struggling with, and subject to, unexpected and often unacknowledged ambivalence. To a world in which Jesse's girlfriend might joke, "'You're not going to kill me, are you?'" To a world in

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[33](Kleinman, 1988a: 159)

which a priest, preparing to lay a blessing on a soldier headed off to war, would flee the raised voice and hand of a veteran returned back home.

Maps

Social Experience and Illness Narratives in Treatment-Seeking and Recovery

Chapter Nine

Narratives and Navigation

In the course of this dissertation, I have outlined how veterans of Iraq and Afghanistan come to experience combat PTSD, moving across time and a series of cultural environments, each of which adds another layer of meanings, images, frustrations, loyalties, and expectations to a veteran's understanding of himself and his illness. It remains, however, to hear from veterans how they understand what has happened to them, what is at stake for them in their journeys, and where they imagine themselves ending up.

Arthur Kleinman, among the most famous of medical anthropologists, has described what he calls *illness narratives*, the tales and accounts through which people make meaning of illness and the suffering that may accompany it.[1] In his writings, Kleinman evokes the many layers of meaning that are embedded in such narratives – social, moral, symbolic – and argues persuasively for appreciating the importance of such meanings and the way they become an essential part of the experience of suffering and healing.

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[1] (Kleinman, 1988a)

In other words, Kleinman suggests that to talk about illness narratives only as stories is to miss their true importance, which lies in the active role they play in contouring the very form of human illness and the lives of which it is a part. Jerome Bruner has similarly written about what he calls "acts of meaning," going perhaps a step beyond Kleinman to suggest that "the lives and Selves we construct" are themselves an outcome of the meaning-making process.[2] For we do not simply *speak* of meaning. We enact it in the things we do and feel, the choices we make, and the lives we work to create. Likewise, the explanatory models we have for illness, the meanings we ascribe to it, and the narratives we tell of it are all active in a very real sense.[3] They shape how we seek out healthcare and support, how we decide whether to participate in recommended treatments or abandon them, whether we feel shame in having an illness or take pride in how we meet the challenge it presents. The way we understand illness and its meanings *makes things happen*; it shapes emotions, decisions, actions, distress, and even the possibility of healing.

In this way, the stories that veterans with PTSD tell are not simply narratives thick with meaning; they are also maps, navigational charts for those crossing wide oceans of life and loss. They are detailed, depicting the currents and landmasses described in these pages – the social, cultural, historical, and political economic forces with and against which veterans with PTSD must orient in charting a successful course to that most longed-for of destinations: a satisfactory life. For all their shared elements, these maps are deeply individual, incorporating the personal details of history and experience and idiosyncratic understandings of PTSD itself. They chart past, present, and future, and change over time.

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[2] (Bruner, 1990: 138)
[3] These issues have also been explored by Daniel Moerman (2002) in his work on the meaning effect.

These maps, and how veterans formulate and navigate them, make up the subject of this chapter. I revisit three veterans – Chris, Adam, and Derek – in order to elicit how their own maps were drawn and where their efforts at navigating life and illness have taken them.

That Extreme Situation

When I first asked Chris about PTSD, about whether he had ever heard anyone say anything helpful about it, he gave a somewhat roundabout answer. He said, "I guess when I was first in the hospital at Lackland, and I just attempted the suicide and I was there for a long time… The doctors, first they thought it was depression, and I was there, I thought, for depression. The doctors started asking about Afghanistan and I'd say, 'I don't want to talk about Afghanistan. I don't want to talk about that shit.' And I'd start freaking out." His psychiatrist responded by pushing a worksheet listing PTSD symptoms across the table to him, suggesting, "'Why don't you read this?'" Chris responded, "'Oh, PTSD, huh?'"

Sitting across the table from me, he mimed going down the list, checking off symptoms. "'Oh, I have that. That happens to me, a lot. Oh." A moment of possibility, of recognition. Oh. "And after I got home [from the hospital] and started doing [group therapy], and not just so much being told about it but actually hearing people say things that seem really almost silly - but they affect your daily life so much. And you realize, *Wow*. I'm not the only one."

In these few short phrases, Chris describes the transition from thinking of his illness as depression to renaming it PTSD, a shift prompted by a change in the diagnosis assigned by his inpatient psychiatrist, and made self-evident to him by the description of familiar symptoms: "Oh, I have that," he says, "That happens to me." He describes the process of coming to accept

the daily ways in which PTSD was interfering with his life, and how this acceptance was furthered by hearing other veterans talk about these "silly" things in group therapy.

Nevertheless, he says, "Even to this day I still have a hard time with the PTSD diagnosis. It's still difficult for me to come to terms with it." He admits to an ongoing struggle with – not the symptoms of PTSD, which he described elsewhere as a reminder that he should be grateful to be alive – but with the *diagnosis* of PTSD.

"It just feels weak," he says, "It still to this day feels like a cop-out. It's not a bullet to the chest. It's something that's so - it's not physical, it's intangible. It's kind of like Tourette's syndrome. I remember seeing when I was a kid, like Maury Povitch or something - and you have a legitimate person who probably had Tourette's and you have children that seem like they were kind of faking it. It's kind of like that. What would cause somebody to cuss out loud like that? It's kind of like the same thing with PTSD. What would cause me to do that?"

He recalls the level of performance he expected from himself and from his enlisted men in the Air Force, a standard to which, in his mind, he can no longer live up. "That's kind of how PTSD is for me. I'm just embarrassed that I let it happen to me. And I know …that it's out of my control, really. When I restructure it and think about those thoughts and stuff… But still - I just disappointed myself, in a way." And not only himself. "I can see somebody looking from the outside – even my best friend Brent, I can see him coming here and looking from the outside and saying, 'Dude, what the hell happened to you? You were fine. When we left [Afghanistan] you were fine. You seemed fine.' I really wasn't, but I seemed that way. I can see him being cynical. I know I shouldn't give a damn what people say, but…I don't know."

Chris' words offer a glimpse of how profound is the conflict between different ideas about PTSD in his struggle to make sense of his illness. He draws on the many layers of his

experience with PTSD, beginning with interactions with his inpatient psychiatrist at the military hospital, and time spent with other veterans in group therapy. He situates these clinically-based ideas about his illness in relation to notions about strength and weakness that he received and passed on during his time in the military. He remembers the Maury Povich show and its portrayal of "intangible" and possibly fraudulent mental illness ("they were kind of faking it"), and then braces himself against shame and self-doubt by recalling lessons in cognitive restructuring that he learned from his psychologist – talking about how when he "restructures it", he realizes that developing PTSD was an event beyond his control. But his distress disappoints him, and disappoints an image of his best friend that he carries with him, a friend whose expectations he imagines he has failed to meet.

The trajectory of his distress has been profoundly influenced by the institutions he has encountered along the way. It was his leadership in the military who first got him into psychiatric care. Chris later ended up in VA treatment after a suicide attempt that led him to conclude that, "I needed to get help or I would have died." His moment of decision, however, was hampered by a problem common to many veterans – the difficulty of wrangling institutional healthcare, in Chris's case at the VA. He remembers calling the wrong number on the first try, then sitting back and waiting a while before he tried again. "Any resistance whatsoever I kinda just stopped. And then I followed up again maybe a month later, and I got in touch with the right person and they got me help." It took about two months to get the necessary referral. "It was like, congratulations, because you're OEF/OIF, you won't have to wait 8 months, you'll only have to wait two. I'm glad I was patient with it. Don't get me wrong, I'm completely appreciative of what the VA has done, but it took a couple of months."

Treatment for Chris meant a combination of anti-psychotic and anti-depressant medications (Seroquel, Wellbutrin, and Trazodone) and a period of group therapy, followed by individual therapy with Dr. Richardson using Prolonged Exposure (PE) therapy and Cognitive Behavioral Therapy (both described in detail in Chapters Six and Seven). Of group therapy, Chris said, "I had to go to classes with these other guys, with Dr. Richardson. I had to read this little booklet on cognitive behavioral restructuring that sounded like bullshit." Later on, he came to think the booklet was useful enough that he brought it to an interview to show me. He already had it in his car, he said, because he had loaned it to a co-worker, an Iraq veteran who he thought might be needing some help. But when he began going to the group, he still was not sure he had PTSD. "I just thought I was weak."

Of exposure therapy, Chris says, "I had to sit and basically recite what happened down there, downrange [while deployed], into a tape recorder and listen to it over and over again. I started with the easiest situations and got to the harder ones towards the end. The first couple [situations] it would take me like three weeks just to be able to get it down on tape. Three visits just to get it down on tape, and these were the easy ones. I couldn't fathom even thinking about some of the things that were destroying me everyday. I couldn't even think about those, much less speak about them."

It was a difficult process. "I was always on edge," he says. "The nightmares would keep coming. Everything just started flooding forward. I was sleeping maybe 2-3 hours a night. I wouldn't take the medication because it – I didn't tell this to my doctor – but it felt like it was coming out. I realized that I could process these things if I was thinking about them, but if I wasn't thinking about them I couldn't process them."

He has come to see PTSD as the outcome of "not processing things that are either too terrifying or because you feel weak or you had a moment of what you feel was cowardice. Some other irrational or not even true feelings you had associated with a given situation, you repress it or allow it to continue to eat away at you." I described in Chapter Three how Chris remembers urinating on himself during his first firefight, and how deeply ashamed he was by this memory, just as he was by the memory that he had not – within the first moments of the attack – lifted his gun to fire. It was only after a delay of some seconds that he realized what he needed to do and began discharging his gun. This delay, and the indignity of his fear, are a significant part of the trauma that haunted him. This is what he didn't want to remember. This is what eats away at him. He says, "The reason I know that it causes the disorder is because when I started to listen to those tapes over and over again, I realized that the disorder itself, the symptoms I was having, went away. So it's got to be related to that. It's just not dealing with stuff that's extreme, and how you were involved in that extreme situation."

Over the course of his treatment for PTSD and depression, he gained enough control over his symptoms that he felt able to leave therapy. Several months earlier, he stopped taking the Seroquel, which interfered, he said, with his ability "to think creatively." He was, by the time we met for the last time, also tapering off of the anti-depressant Welbutrin, hoping to be free of his medications, although he still gets depressed. "I still get in a really bad mood, with the schema of doubting myself, the self-deprecation comes back quite a bit." He has incorporated his psychologist's teachings into his thought process. "Dr. Richardson says that you just identify it, so it becomes a constant constant check, what am I thinking? Is this an accurate thought? What is the truth of what is happening here? I've been able to apply that for my own psychological well-being. So instead of internalizing things I've been able to compute

things a little more rationally, and I think that's been able to help with things I had wrong with me long before I went to Afghanistan."

Perhaps most strikingly, his way of perceiving the world has changed since the treatment, coming to bear more resemblance to how he observed his surroundings before he went to war. He says, "I'm not living in the shooting gallery that was my mind. Everywhere I went it was just," and he swivels his head back and forth as though looking to all sides, identifying imagined objects and the potential threat they pose:

"Bridge. Danger…. Sniper.

"Guy walking…. Bomber.

"Car pulling up fast in the rear view mirror… Bomb.

"Trash on the side of the road…. Bomb.

"Pot-hole filled in freshly…. Bomb."

This was how he saw the world.

Now, by contrast, he says, "It's not that constant edge. When I'd drive from my work to my house, I'd just be sweating bullets every time, you know. Because it was just like this race - this race for life. I don't feel that way anymore. It's great."

Of his PTSD, he says he is "probably 98% cured of Post-Traumatic Stress Disorder. Other than a few nightmares here and there, or I see things and every once in a while for a half second I think I'm somewhere else. They're not crippling things. They're just things that I'll probably have to deal with the rest of my life. And if I didn't have to deal with those things, because I'm human, it would probably mean I wouldn't be human." After all he has been through, not to hold on to these memories would seem wrong to him. He says, "They're things that I want to keep with me, just as a reminder."

His experience with exposure therapy, positive as it has been, has led him to become something of an advocate for PTSD treatment. His voice hardens as he offers, "I can't imagine – if somebody says it's not treatable, they're full of shit. They're not trying. Or they're not suffering enough, maybe. Maybe it's not that bad for them. Because when it's bad, you definitely want to be helped."

It strikes me that, in this last statement, Chris provides some measure of how treatment has changed his life, a change that has resulted in his having ideas about PTSD and the possibility for recovery that are very different now than when he was first diagnosed. At the same time, his words reveal his continued reliance on a military mindset: if therapy doesn't work, you're just not trying hard enough. Toughen up, soldier.

Nor does it seem that Chris' view of PTSD can be defined solely in terms of an *explanatory model*, that term anthropologists often use to describe the cultural framework for a given illness. In his case, the idea of an explanatory model would seem to convey an overly fixed idea about the disorder, complete with a clearly identified cause and expected trajectory. Chris' perspective on PTSD is, by contrast, an amalgam of sometimes contradictory ideas. He sees it as evidence of some flaw in himself, a weakness, and yet also something he acknowledges and accepts. He views PTSD as the outcome of trauma – traumas he has described in great detail during audiotaped therapy sessions – yet remains unclear about its origins in his life, asking, "What would cause me to do that?" It is a phenomenon he does not fully understand, and yet over which his ability to practice cognitive restructuring techniques has given him some mastery. It is an occurrence he finds confusing, that he doubts somewhat, just as he doubted the kids with Tourette's he saw on TV, and so hearing others talk about their similar experiences provided him a sense of deep relief: "Wow. I'm not the only one." His ideas, too, are drawn

from many sources: his years in the military, days at home on the couch watching the Maury Povich show, experiences in group and individual treatment, psychological views of cognition and behavior and psychiatry's reliance on medications. His words demonstrate that he has taken up particular aspects of his treatment – the idea of cognitive restructuring, the idea of PTSD as a diagnosis that applies to his own experience – while rejecting others: his medications, for example, which he thought interfered with the process of the trauma "coming out" while he was engaged in the most strenuous period of exposure therapy.[4]

His wife, he acknowledges, still think PTSD is "something that I may use as an excuse," although he takes some responsibility for this. "The few times that I've ever tried to approach her about it, it's always at the wrong time. It's always at a time when it could be construed as an excuse. Like if I'm angry and I want to be alone, it's not just that I'm angry and I want to be alone. And she gets upset about that and says I'm trying to withdraw, and I can't think with my PTSD acting up. But I can't say that to her because it sounds like an excuse." This remains an issue between them. "Part of the reason that I wanted to have treatment and get better was so that I wouldn't have that excuse."

He remains humbled, too, by the inadequacies of his own career success. There was a time shortly after Chris' release from the hospital, when – despite working two jobs – he was

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[4] It is unclear whether Chris received this idea from a clinician, although he did describe hiding his decision to stop taking the medication from his provider. Nonetheless, this idea reflects a concern expressed by some psychiatrists and psychologists that certain types of medications – most importantly, sedatives like the benzodiazapines – may interfere with the processing of trauma during exposure therapy. This has yet to be demonstrated in clinical trials, although there is evidence that the combination of benzodiazepines with psychotherapy in the treatment of panic disorder is less effective at bringing about long-term symptom reduction than psychotherapy alone (Spiegal & Bruce, 1997; Watanabe, Churchill, & Furukawa, 2009). Given that the use of habituation in treatment for panic disorder relies on similar principles as when used in exposure therapy, it is accepted by many clinicians that the sedation effects thought to interfere with habituation in treatment for panic disorder would likely also interfere with exposure therapy for PTSD.

unable to pay the bills and had to fall back on aid from a private veterans organization. He was grateful for their intervention, but stung that his hard work was not enough to make ends meet. Chris' feelings here run parallel to the findings of Susan Faludi in her work on changing expectations for American men in the mid-20th century.[5] Faludi describes how American manhood has increasingly been defined by the expectation that men will succeed, often by acting in control of their environments, even as a changing national economic structure and social norms have increasingly deprived working- and even middle-class men of either control or opportunity. Thus many men's expectations for themselves, and those placed upon them by others, may be founded on unrealistic assessments of the available prospects.[6] Among the veterans in this study, the lack of economic and educational opportunities that often pushed them to join the military in the first place were still there after their separation, unresolved by time in the service and the benefits accrued there. Like Chris, many men reported finding themselves – at least at some stage – unemployed or underemployed, unable to provide for themselves or their families as expected.

Now past the early economic struggles, Chris remains troubled by the fact that, since the military, "I'm just not moving up." He struggles to find a view of himself that he can live with, that can straddle both his military past and his hopes for the future. "At some point I'm going to have to put the military behind me, because I feel like I'm still in even though I'm not. And I feel ashamed when my friends from the military call me." It has gotten easier to face

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[5] (Faludi, 1999)

[6] One extreme case comes to mind, that of a young veteran who was living out of his El Camino at the time we met, and who had no education beyond high school, no vocation or skills, and no sense of where he was going. Nonetheless, he cheerfully insisted that he was going to have a Porsche one day, because he saw others around him with Porsches and so it seemed reasonable that he, too, might realistically aim to have a Porsche.

them since he got the job with the credit card company. Before that, he worked for a while as a shoe salesman in an upscale department store. "I was making great money, but I was still selling shoes. You know? And I could feel people – although I'm sure none of them said that – but I could hear them saying it, 'I saw this dude run headlong into enemy fire… I saw him pull people out… I saw him do this, I saw him lead us, and now he's selling shoes?!' You know what I mean? And that's pride once again, but that's the part of me that wishes I'd just died over there and been left a picture on the wall in the NCO club."

For Chris, there is no separating his struggle for a post-war identity from his struggle to live up to the expectations he believes those around him – his military buddies, his wife, even his children – might have for him. When he has struggled with the urge to kill himself, these are some of the worries that have tormented him. When he was first suicidal, "people were like, 'But you have so much to live for – your kids!' And that's what I can't even express to people, that at that point it just doesn't matter. People who've never been suicidal… I wanted to kill myself *for* my kids! I didn't want them to see me. I was so miserable and depressed and ashamed and low, I didn't want them to see me. A lot of people don't understand that."

Now, he says, he sees it differently: "I do look at my children and I do want to have a life. I've come to the realization that, at this point, I'm better off for them alive."

In the end, what jumps out here is that Chris' view of a life worth living – and for a man who has struggled with the desire to kill himself over a period of several years, this is a matter of some importance – is driven by notions of both identity and obligation. He imagines a life in which he has a sense of himself as someone his children can look up to. Part of this desire involves a sense of "moving up," engaging in work that not only meets his financial needs but also allows him to retain the identity he acquired in the military, as the man who ran "headlong

into enemy fire." He also desires to live in accordance with the imagined expectations of his friends from that time. He is unwilling to go from being a heroic leader to a shoe salesman because this feels like an unbearable come-down. He feels the pull of his obligations to his children, but acknowledges that this has not always felt like enough to maintain his will to live in times of crushing distress. It has taken the help of others to keep that will in motion – his wife and children, but also his friends, military leadership, and clinicians. It was this net of joined forces that caught and held him when he was falling. He is, for all their efforts and his own, still alive.

A Failure to Reintegrate

After 7 months in Iraq with his Marine Reserve unit, Adam returned to Camp Pendleton to face the usual short period of briefings and paperwork prior to release. He was already sensing that he was not alright, and he began drinking almost as soon as he landed back in the U.S.. "I was having horrific nightmares and I wasn't sleeping. I mean I literally wasn't sleeping. I would stay awake or I would drink so much that I would pass out. And of course I would wake up an hour later and start drinking again."

He failed to find the post-deployment briefings at Camp Pendleton particularly helpful, even as they described the same problems he was already having. "The Staff Sergeant would stand up there and he'd read a piece of paper that says, 'If you're having a, b, c, and d, they need you to go do h, i, j, whatever.' And of course you're home, you just got home, and particularly from your first deployment – you're home, you're ready to go see your family, your friends. I mean, you're not *listening*. Who are we kidding here?"

Back at his home unit, there was another briefing on readjustment and PTSD. In this one, the information was roughly the same, but presented "in a manner in which it was…if you were smart enough, you understood that they were basically saying – not in so many words – [that] whatever, you just need to suck it up. You just need to deal with it. I mean, they didn't *say* that. It was just, 'if this, then you go do this…' It was kind of an aside almost."

Adam got stuck somewhere between the two messages he heard in the scheduled briefings, recognizing that his nightmares and drinking might signal a larger problem, but unwilling to be the one who admitted to needing help. He got other men in his unit to seek care, and when necessary, he says, "We physically took them to go see people. But when it came to me, I refused to. What's good for them isn't good for me, so to speak. I just felt like it was weak. It was weakness. It wasn't supposed to happen to me. I was supposed to be stronger and bigger and meaner, and I was supposed to be able to deal with all those things." His resolve to tough it out lasted about six weeks. He remained depressed and unable to sleep, and in mid-June, sought help from the clinic on base.

This first encounter with mental health treatment made an ugly impression. The doctor, as Adam remembers, did not even ask him how he was doing before he began berating him for seeking help at the post clinic, rather than through one of the official channels: at a larger local base or through the Tricare program (which enables service members to receive their healthcare in the civilian sector). "So that," says Adam, "was when I lost it. I got up and got in his face and started just screaming and yelling at him. I mean, a little sergeant – E-5 – doing this to an E-7. And he knew. He backed out and got out of the room and nothing was ever said about it. But I put him in his place." Another doctor came in then and made the same referral suggestions, more civilly, and Adam wound up seeing a local civilian psychologist. Even so, he

says, “I did that very much under the radar. I didn’t make a big deal out of it. I was still at that point very concerned about my career. I didn’t tell my friends, I didn’t tell anybody.”

A few months later, Adam left the Reserves for good. After a long post-deployment leave, he arrived at Friday night formation for his first weekend drill and, within a few minutes, realized that, “it was just everything that I didn’t want it to be anymore. I got out of formation and went and got a check-out sheet and left that night. That was it. I never looked back.” I asked him what he meant by “everything I didn’t want it to be” and he answered, “I was always very gung-ho, and I loved it and I lived for it, you know. It was everything. And I just realized after having served on active duty and having been in combat – I realized the monotony of what they did in the reserve unit. And how some of those people that were higher-ups just had no clue what they were really doing. It was a circus.”

Part of his dissatisfaction came from his role as an NCO, caught between the needs of the enlisted men for whom he felt responsible and the orders coming down from superior officers, which he felt compelled to obey. “I would sit in meetings and argue with people, because I was a platoon sergeant, so it was my job to run interference. Wherever I could, you know, and try to dissuade stupid ideas and try to keep my Marines from getting wrapped up in having to do stuff that was a waste of their time.” He explained that in the Reserves, the one weekend a month obligation means that there is less time to do all the maintenance and training and other work that needs to be done. Under such time pressure, he felt resentful of “playing games” or “just doing stuff that doesn’t make sense.” As he stood there in formation that night, debating whether to stay or whether to go, he found that he “just didn’t have the heart to deal with that stuff anymore. So I got out.”

He went back to school to finish the college degree he had been working on before deploying. He had regular meetings with his psychologist, who diagnosed him with PTSD and major depression, and a psychiatrist who prescribed Zoloft for his depression and Ambien to help him sleep. His psychologist encouraged him to try a controversial treatment called Eye Movement Desensitization and Reprocessing (EMDR), which involves combining rapid eye movement (or other stimuli) with a detailed re-assessment of traumatic events. EMDR is unlike the exposure therapies in that, while it requires the individual patient to remember traumatic events in detail, those events do not have to be written down or shared with the clinician.[7] Of EMDR, he says, "I hated it. I absolutely hated it. Looking back on it now, I feel it was way too early in my progression in PTSD to have done EMDR. Because I didn't need EMDR to bring back those memories and those feelings and sensations and all that. I could sit there and look you in the eye and talk to you for two minutes and I would have all those feelings and smells and sounds and everything right there. So I hated it. I hated EMDR with a passion." Although he continued seeing the psychologist, his frustration with the treatment reinforced his initial discomfort with care-seeking.

He finished his remaining college courses within a semester, and then made the move to San Antonio to begin a new management job with a large commercial contracting firm. His wife was working in Santa Fe at the time, and although they saw each other every weekend, he lived alone during the week. He admits that this "probably wasn't real good for me because I didn't

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[7] (Silver, Rogers, & Russell, 2008) The evidence for EMDR's effectiveness remains controversial and less conclusive than that of PE and CPT (IOM, 2007). Nonetheless, one of EMDR's strongest recent proponents has published an interesting analysis of the treatment's outsider status within the field of professional psychology, arguing that it is professional bias and resistance to change, rather than a lack of evidence, that perpetuate the controversy around EMDR (Russell, 2008).

have anything in the refrigerator except beer and liquor, and so I drank and I drank and I drank and I drank and I worked."

He drank hard, but he worked hard too and was successful in his new job, building a solid professional network and earning more than $100,000 within his first year. He was not getting along with his boss, however, and decided soon after that it was time to go into business for himself. In the meantime, he found a private psychologist in San Antonio who agreed to treat him without EMDR – a key stipulation he put forward from the beginning – and lacking health insurance, continued to pay out-of-pocket for therapy sessions, which he was attending as often as twice a week. He estimates that he has spent somewhere in the neighborhood of $10,000 in private care over the past few years. For all the expense, he could not make himself seek out the care for which he was eligible at the VA. He would receive calls from his former Marines – they would tell him they couldn't sleep, they were having nightmares, etc. – and he would tell them to go to the VA. Once again, however, he held himself to a different standard. He says, "I just had something wrong with my head. I don't have anything wrong with me physically. I'm not worthy."

This went on for a year or so. Adam's wife found a job in San Antonio and moved into the house with him. His new contracting business got off the ground and picked up some big jobs. He applied for service connection for his PTSD and received a 50% disability rating within just a few months. His application was so successful that he began counseling other veterans on how to get through the benefits application process as efficiently as possible. He saw his psychologist regularly, and they discussed his problems, debated solutions, worked on understanding and processing his experiences. He made gradual progress, he says, until about January of 2007, when things began getting steadily worse again.

On reflection, Adam credits a convergence of two developments with the decline. First of all, January was about the time when he began talking with David, a close friend still in the Marines, about starting an advocacy group that would speak up for the rights of local veterans. Building on Adam's experience with helping other veterans apply for service connection, the group's mission would be to connect veterans with local resources as needed and to organize a network aimed at keeping veterans' issues at the forefront of state- and local-level political attention. Adam began devoting an increasing amount of time and energy to the project, building local networks, identifying a list of key priorities, and applying for grants.

Meanwhile, David was back in Iraq, serving a third tour. It was hard for Adam to watch his friends return overseas without him. He felt as though, in leaving the Reserves, he had abandoned them. So when David called him on a satellite phone from where he was stationed in Mosul, Adam was all ears. David's staff sergeant had left him in control of a police station in a contested area, overseeing a 20 man detail and an Iraqi police force faced with daily sniper, mortar, and rocket attacks. "So daily [David's] got Marines getting wounded. He's not getting support. He calls the quick reaction force and it takes them 35 minutes to get there because they get ambushed on the way. Anyway, he has no one to talk to. You're in charge, you don't talk to your lower ranking Marines. So he called me, and I guess they intercepted one of the phone calls, and were going to charge him with breach of operational security."

Confronted by his superiors, David broke down and admitted that he was so overwhelmed he was no longer functioning. He was promptly given a medical evacuation out of Iraq. "And man," Adam says, "I felt such guilt for not being there. If I could have walked into the unit and said, 'I want to be there in 48 hours, give me a rifle and a flak jacket, I'll go. And if they would have done it I wouldn't have looked back. In a heartbeat. In a heartbeat." Returned

to his home in Houston, David became embroiled in a series of convoluted miscommunications between military, VA, and civilian healthcare providers. Adam conveyed the story, thoroughly disgusted, in such exquisite detail that it might have been his own.

This was the problem he came face-to-face with in January, when he began to slip back into depression and anxiety. He was overcome by the convergence of starting a new endeavor (the advocacy group) just at the same time that he was watching his best friend's life fall apart. The guilt was too strong, and was matched, he thinks, by unconscious fears. He says that, "When I say I started regressing in January, part of that probably was me saying, 'Holy shit, you're getting positive about something. You're getting positive about life again. You can't do that.'"

And so, from a period during which he felt like he was getting better, all of a sudden he felt more and more depressed, and the anxiety and nightmares began again. The regression was gradual, but by that August, he was no longer able to keep on as he had been. Oddly enough, when it came to a crisis point, the precipitating factor once again had to do with David, who had come for a visit. The two went out to Adam's deer lease in the south of the state to do some hunting. Adam says, "We didn't really talk about the war, per se, but we didn't have to. You know, there's just that sense." After a few days out there, they drove back to San Antonio, and David left the next morning, headed back home to Houston. Within hours, Adam remembers, "I was having a major, major panic attack, and I mean, I just absolutely lost it. I was just a very small short time away from committing suicide, and I didn't know what to do. I didn't call anybody. I was just – I left [work] and the only thing I could think of was the VA, so I drove there." He presented himself at the psychiatric triage unit, and that was the beginning of his experience with VA healthcare.

As it turned out, David was checking himself into a hospital in Austin at just about the same time, having himself fallen apart on the drive home. It was several days later before Adam found out; neither had called the other.

I find it poignant that both of these men presented themselves for psychiatric care on the day they separated, after a visit in which – according to Adam – they said nothing about the war itself. It was as though their shared combat experiences lingered in the space between them, and that unspoken presence was enough to undo some delicate inner balancing act. It is perhaps the more extraordinary that, when I asked Adam who or what had been most helpful to him in the preceding years, he said without hesitation, "David. Before we left [for Iraq], we were friends. But I consider him to be my best friend now, and I think if you asked him he would probably say the same. David and I can sit in a room and you know, we don't have to articulate our feelings because we know exactly how the other one is feeling. We know exactly what the other one is thinking. We're both going through very similar situations with Post-Traumatic Stress Disorder and the VA and our feelings. So we can relate to each other 100%."

That relationship, in turn, has played an important role in shaping how Adam views his own experiences. David's frustrations with VA and military healthcare have fed into Adam's own. They compare regular notes. Talking about his involvement in group therapy at the VA, Adam said that he had expected to also be offered private counseling sessions, since that was what David was receiving at the VA in Houston. And although he did not say this, I cannot help but wonder whether having another combat veteran and Marine to talk with also helps Adam to deal with the lingering sting of viewing PTSD as a "weakness." If he was not, in fact, "stronger and bigger and meaner" than the illness, then at least he was not alone.

Meanwhile, frustrated by his own institutional encounters – and those of David and other veteran buddies – Adam has become an articulate advocate for veterans' rights. He is a repository for stories of unjust treatment. He believes strongly that veterans are in the best position to help other veterans.

When I asked him about PTSD, he responded that, "PTSD to me is…the reaction to the trauma that some of us experience. [PTSD] is when you come home and it's your failure to properly reintegrate into society. It's – everybody wants you to do that reintegration process. They want you to be okay. They want you to be normal. They want you to take your camos off, put your civvies on, wash 'em and put 'em in the closet. And they want you to put your boots and jeans back on, or your trousers and your loafers or whatever the hell it is that you wore, and they want you to go back to your normal life, the way that you were. And a lot of people can't do that. And so, whether you call it PTSD or anxiety disorder or whatever, you have failed to cut loose those experiences."

He sees PTSD, in other words, as the failure to do what is expected of you. It is the failure to jettison the past and make the change from military to civilian garb, a sartorial shift cloaking an equally dramatic inner change. And that, Adam says, "is the thing that people don't get. And that's the thing that I've been struggling with. I feel like I lost my identity that I had before, pre-deployment. Who I was before doesn't exist anymore. And I gained a new warrior identity, and I became that. And I'm still that. I haven't lost that. And I'm almost afraid – I'm very much afraid of letting go of that. Because now that I've been removed from Iraq and I've been removed from the time that identity changed in me, I'm afraid of the pain and suffering that's going to come with changing again."

This fear may help to explain why, amidst great change, he has sought some continuity. There are marked similarities between his new role as a veterans' advocate and his previous responsibility as a platoon sergeant whose job it was "to run interference". Given that his only stated regret about leaving the Reserves lay in not being able to face combat with his buddies, there is a certain rightness to the fact that he has devoted himself so fully to helping other veterans face down the VA healthcare and benefits systems. Like Chris, Adam's attempt to navigate PTSD has lacked the orienting vision of a post-war identity. Pushed to move forward with no clear goal in sight, they have both steered by their obligation to others - Chris to his children, and Adam to his fellow veterans.

Even getting to this point has, Adam acknowledges, required "two years of work." He worries for "all my guys who are just starting this process who have no idea, who've been home for six months and they're realizing, they're starting to acknowledge that there's an issue. It's not PTSD because 'that couldn't happen to me!', but there's an issue. They're lost. They are out on the water without a sail. They're up shit creek without a paddle. They feel very much lost. And abandoned. And alone."

This concern for other veterans has become his guiding light. Now, he says, "when I talk about the advocacy group, all of a sudden my life has purpose and meaning. I feel very much that my purpose and meaning was to go to Iraq, and my purpose and meaning was to lead men into battle and to do the things that I did. And I didn't expect to make it home. But when you do – it's like, now what the hell do you do? If you consider [Iraq] – like I do, probably 29 out of 30 days – to be the pinnacle of your life, then where do you go from there? And I'm sure that a lot of veterans feel that way. To them, that was it. That was the coup d'etat. That was

everything. So now what? They have to find something meaningful and purposeful. So I think I've found that and we're moving towards it."

Adam has taken the navigational map he developed in an attempt to understand his own distress – his own way of understanding PTSD and the suffering it has brought him – and used it to derive a way of helping others. This has, in turn, become a way of helping himself.

But as much as I would like to say here that Adam is sailing along, confident in his vision and moving steadily forward, his story is not so simple. Finding meaning and purpose has not been enough to ease his distress. He has nightmares, still, every night – often about Iraq, other times about homicidal violence here at home. His relationship with his wife remains fragile, and, although he credits her with great patience and understanding, they are struggling to find common ground. He cannot share his feelings with her the way he can with David. He finds it hard to respond to her when she reaches out. He values his psychologist and the help she has given him, but his symptoms remain uncontrolled and – given his negative experience with EMDR – he remains hesitant to try other treatments. The advocacy group seems to be stalled and on hold. He is a man of many talents: intelligent, capable, well-spoken, likeable. He is from a prosperous family and has been economically successful himself, avoiding the financial problems that plague so many veterans. He has all the tools for building a successful life, and yet still he struggles. Applying his description of other veterans to himself, he is on the water without a sail. Up shit creek without a paddle.

Having a map has not been enough to get him to shore.

The Aftereffects of Suffering

From the time Derek made the trip from Walter Reed to San Antonio's Brooke Army Medical Center (BAMC), the focus was on his amputated leg. For nearly a year, there were repeated surgeries as the surgeons attempted to pull the fragments of his lower leg together in a way that would enable him to support a prosthesis with a minimum of pain. Early in his treatment, Laticia sneaked him out of the hospital one afternoon – hopped up on antibiotics and painkillers – and they drove to the courthouse to get married. When Derek jokingly asked the presiding official for a special "veterans' discount," the judge took one look at his bandaged leg and gave them back their $50 court fee. Afterwards, they stopped at a gas station for Gatorade and then headed back to the hospital, where Laticia, as Derek's wife, now had the right to receive information relevant to his care. Derek still teases her, "I was on drugs when we got married."

I asked her, "At the time, how did you see him dealing with [his injury]?"

"He really…there was really no times when it was, 'Poor me,' or the sadness. It was 'Okay, what do I do now? Let's figure out what the plan is now. We can move forward from this, let's do this, let's do this.' It really wasn't any type of bad attitude. Maybe a little short temper. He would get frustrated easily and he would have a little bit of a snap. Patience. Really wasn't a lot of patience. It was those type of symptoms. But not really the beating up on himself or placing the blame on anybody."

In those early days, their greatest challenge was getting Derek's physical health squared away. They spent four months living in outpatient housing on Ft. Sam Houston, where they had a hotel room to share with Laticias' two little boys. Derek had to get to know them all over again after his long absence.

Through a long hot summer in a crowded room, Derek says of Laticia that, “Her biggest complaint was [that] … for a long time I was extra clingy. I wanted her by my side at all times. I had missed her for eight months. I had gone through being blown up three times in one day, any day can be the last one. So I was already mentally trying to figure out that I might never see her again. And then seeing what happened to [my friend] and being in an explosion and getting injured myself, and seeing that I was still here and feeling like it was on borrowed time…and it drove her nuts.”

Laticia agrees. “You don’t want to say – ‘Oh my god, he’s right there.’ But it was like that, ‘Oh my god he’s right there!’ If we had been sewn at the hip, that would have been great for him. But you know that left me no extra time or personal time or kid time. It was me and him. That’s how it was. He was very clingy. Very clingy.”

Every time she left the room – to take the kids to the park, to go grocery shopping, to go pick up his medicines at the pharmacy – he would ask her, “Where are you going? Where are you going? Come back.” When she was in the room, he wanted her next to him, where he could reach out and stroke her hand for hours on end.

“I have very sensitive skin,” she says, “so the constant petting would try my…” But she cuts the sentence short, remembering how she would remind herself, “He’s hurt, he just got back, that’s just part of him.” Even so, she found it to be a challenging transition, the move from being an independent woman caring for her children alone, to caring full-time for a husband who wanted her present every minute of every day. She got through it by drawing on a view of Derek that made these annoyances seem bearable and mundane.

“With all the things that he went through,” she said, “there’s [nothing] in the world that would change my outlook on the world to match his. So that the way we see each other would

be the same." It wasn't simply that they were different people. She saw the differences between them as an outcome of the suffering he had gone through in Iraq, identifying it as something like what is often called post-traumatic growth. Rather than viewing him as emotionally wounded, she saw him instead as more compassionate, more loving, because he had lived through these things. As she says now, "He's always going to be in a higher echelon of compassion and love for me because he has gone through those experiences and the life that he sees is completely different from how I see life. I will never be able to be on that same level with him. My thing," she concludes, "is not to let it push us apart. Not let it – he's rubbing me, he's constantly right there – and not let that put me in a way where he's annoying me or something. Because I will never have the same outlook on life and love and people that you care about that he does."

And so, with this in mind, she cooked meals to help him gain back the weight he had lost. She kept track of his medicines and appointments, and did her best to entertain the kids until school began again. Day by day, they pushed on through. Derek spent months at the Center for the Intrepid (CFI), Ft. Sam Houston's new state-of-the-art rehabilitation facility for wounded veterans, learning to walk on his new prosthesis. He began thinking ahead to life after the military, and applied to one of the local colleges. He and Laticia found an apartment off-post and got the boys settled into school. Derek began attending classes, and it was then that he was forced to realize that his problems were not only those related to his injured leg. Not only was he short-tempered at home and unwilling to go out in crowds, but he was increasingly late to class because he felt the need to check and double-check classroom buildings for snipers and other potential threats. Then, as I described in Chapter Four, came the critical day when a professor put a video on in class with no introduction or description of its content; he was

shattered by the unexpected vision of an Iraqi mosque exploding, so undone that he had to leave class. He sought out his vocational rehabilitation counselor at the Center for the Intrepid and she got him linked up with the VA for PTSD assessment.

Like Chris, Derek has gone through a fairly standard course of treatment under the new time-limited model. His psychiatrist put him on medication to "even out" his serotonin levels (he believes it to be Seroquel, but wasn't sure).[8] He began individual therapy with Dr. Richardson. I asked him to describe the treatment.

"It's cognitive behavioral restructuring. So you go in and the first [session] is like a class on PTSD and how it's structured and the different phases and stages of it. And what I liked about it is it's cognitive. And I'm very – I have to have my mind engaged or I'm not happy." Derek felt comfortable with the early sessions because they suited his intellectual inclination. The classes changed how he understood the intense sensory and emotional responses he was having to the world around him. "[Dr. Richardson] explained that what happens is, when you're in combat, all your senses get picked up [heightened]… Fight or flight kicks in. And because we've been in [combat] so much, we bring it up and we can't bring it back down." He found it helpful "to actually cognitively understand the thought process, the reactions, to see yourself go up and then go down and to realize subconsciously that it's going to be okay."

Following the initial classes, Derek became involved in what psychologists call the "in vivo" aspect of PE treatment, which required spending time in scenarios that provoked a fear

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[8] Seroquel (quetiapine) is one of the atypical anti-psychotic drugs commonly used to treat PTSD. Although there are no published reports on its effectiveness for use with PTSD based upon randomized clinical trials, there is some open-label evidence for its effectiveness in diminishing intrusive symptoms when used alongside selective serotonin reuptake inhibitor (SSRI) anti-depressants (Ahearn, Mussey, Johnson, Krohn, & Krahn, 2005). It has also been shown to reduce symptoms among combat veterans whose PTSD has psychotic features (Pivac & Kozaric-Kovacic, 2007).

response. "Things like that," says Derek, "were my homework. Go somewhere crowded, then stay as long as you can. Once you feel like you have to leave, stay 10 more minutes. My case was simple – walk the same route to class every day" – instead of varying his route, a common tactic used in combat zones to avoid attack – "and then go straight into class and sit down." The first week, he found it almost impossible. "By Friday I was more okay with it, but Monday and Tuesday I was not happy."

The second phase of the treatment, according to Derek, focused on cognitive restructuring. "You identify situations that make you nervous and you write 'being in a crowded place makes me nervous,' and then you analyze it. Is it really something you should be nervous about, and if so, keep it. Are you overreacting? Are you not overreacting? And that helps a lot, because you can see on paper, 'No, I really shouldn't be this bothered in this situation.'"

Derek learned to think critically about his anxiety, to become aware of his distress, getting in the habit of quantifying his discomfort on a scale from 1 to 10 (1 being no anxiety, 10 being unbearable). The final phase focused on talking about the combat events that Derek found more troubling, revisiting "incidents," Derek says, "that I had repressed for over a year. I recorded them and had to listen to them daily and then had to record my anxiety level. And watch it steadily go down."

"What was that like?" I asked.

"The first two or three days it was torture. I told Dr. Richardson, this is something I really don't want to do. I repressed this for a reason. But at the end, I think it was supposed to be an 8 week program but I finished it early. It got a lot better. Even talking to you about the situations – yeah, it brought some anxiety, but where it used to get to an eight, now it gets to a two or a three."

Laticia broke in here to ask him, “When I listened to [the tape] with you – that one time I listened – how many times had you listened to it?”

Derek replied, “Three or four.”

Laticia nodded as she turned to me, describing her response to hearing the tape of his war stories. “The floodgates in my eyes must have opened up to full gauge because – some of those stories that he told – especially about, the girl was on there, and then another one of the Iraqi Army guys, and Derek holding his stomach so the blood wouldn’t come out any more, like a tourniquet or what do you call it?

“I had a field dressing on his stomach,” Derek says.

“Just hearing some of the things that he went through,” Laticia continues, “was like a real eye-opener for me. I think if the wives would listen to that – I think it helps. But it helped me - not understand, but at least be able to look at the picture to help me understand. You can’t go into the painter’s mind and know what he was thinking when Monet was scribbling, but at least you can know… So I can better see now with the crowds or not wanting to do this, or anxiety towards that. Although it’s still very very *very* frustrating, I can at least kind of see it from the other side. I don’t think I even listened to the whole thing. I think I listened to about half, for about 30 minutes? And cried like a newborn baby. It was emotional. And then just to know that was just a couple of incidents of what he went through over there. It was an eye-opener.”

Like Chris, Derek no longer goes to treatment. He says that he is much better. “I don’t walk around buildings anymore. I go out in groups of people.” Together he and Laticia describe visiting a local Chuck E. Cheese [the chain of enormous pizza parlors with indoor arcades and jungle gyms] and how Derek – who initially refused to go inside, choosing instead to sit in the

car and study – ended up walking in and chasing Laticia and the kids around for three hours, oblivious to the crowds.

"I had a blast," Derek admits. Laticia laughs, and he goes on, watching his wife's face. "I was running around – I must have freaked you out with all the obstacles I did."

"No, but did you take your leg off?"

"No, it got trapped in the safety net and fell off." He grins, remembering, and says, "When I chased you through the jungle gym, that was fun."

"I was laughing, but inside, I was like, 'Wow."

He turns to fill me in. "She came and threw this little ball at me, and tried to run down like I couldn't get her. I just moved like a snake, put her on my knee and grabbed her. It was fun, and at my appointment with Dr. Richardson that week, I said, 'I don't know what you did, but thank you, because there's no way I would have been able to do the things I did over the past two weeks. At all."

I asked Laticia, "Do you see a difference in him?"

"Mmm-hmm," she said. "As far as crowds and willingness to do other things and going out of the house, and shopping is so much better now. That portion is still there. I don't think he'll ever not be clingy, but I'm okay with that now. Even though it's a little frustrating, I just chalk it up to that's just who he is and it's not PTSD. He's a lot more understanding, he's a lot more patient – a *lot* more patient now. I notice a big change. A huge change."

"There's still nightmares," Derek says.

"Still nightmares," she agrees. "Times I have to shake him. 'Wake up! Wake up!'"

"They're different now," Derek points out. "Before it was always a replay of an event in Iraq. And now it's sometimes in Iraq, sometimes it's not. Like last night I had one and I woke up

confused – not anxious, not worried, not sweating. Just confused. Wondering whether I was going out of my mind. I was in the Army still, and somehow I was in Serbia. Never been to Serbia. It's in some of the stuff I'm reading about and that may have triggered it. But we were on one side, and the Serbs were on the other side and just lobbing artillery shells back and forth, and none of them were detonating. Which struck me as probably – could be an accurate thing. But one of them came and detonated right by me. I could feel the shock wave lift me up and put me down, and then I climbed over the sand bags and went back into another room and went to sleep."

He still dreams of the Army, of bombs that land too close. In these new dreams, though, the bombs fail to explode. If they do go off, he finds that he can simply ride the shock-wave back to sleep. He does not wake up sweating and anxious.

Like all of these veterans, however, he can identify ways in which he has changed from his pre-war self. For Derek, these changes have been both good and bad. He says, "I look at life differently. Sometimes I'm short-tempered and my patience is down. My stress level is almost none. I go to school and I laugh every day at the college students getting worked up about tests and papers, because as long as nobody's shooting at me? Shooting RPGs at me? I can handle almost anything. And yeah, I might snap here and there, but five seconds later, it's gone. I'm a relatively mellow person. Things that used to bother and stress me out aren't that important anymore. And at the end of the day, I still go home to my family, I don't go home to some bunker out in the desert somewhere. I still get to eat. Little things that everybody else takes for granted, I see differently now." He has less stress and more nightmares. He has traded a leg for his younger self's unnecessary worries. He values the simple blessings of life: home, family, enough to eat.

I turned to Laticia and asked, "What do you think of PTSD? How do you think about PTSD at this point?

She thought on this for a moment, and then answered, "I guess if I was to tell somebody what PTSD would be in the most comfortable language, I would say it's all of the aftereffects – feelings, emotions, mental thinking – that one person has after being in an intense and stressful, dangerous environment over a long period of time. All the anxiety – you have to make quick decisions, so you're impatient. All those emotions that go with it. All of the stress and the emotions and the anxiety – all that a person carries with them even though they're not still in an environment that's stressful."

When asked whether PTSD continues to impact Derek's life, she says thoughtfully, "I think it's a presence. Not so severe as when he first came back, but it still affects him. I figure it's probably always going to be a presence in some sort of way, because it's something that he has to live with and deal with and constantly make an effort to overcome and change."

And so, little by little, they work towards the goals they have set for themselves. Derek looks ahead to the day when he finishes his college degree, and believes he has the networks and the expertise to start his own business in advertising. When Derek is finished with school, Laticia plans to use benefits available to wives of disabled veterans and go back for her masters degree in business.[9] They have a long-term vision of life in which their kids get old enough to graduate high school and leave the house and they can begin traveling and living more for themselves.

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[9] Under section 301 of Public Law 109-461, effective December 23, 2006, the spouse or child of an individual who is determined by the VA to have a permanent and total disability that is service-connected and who is to be discharged from the service because of this disability may be eligible for educational assistance (for more information, see http://www.gibill.va.gov/GI_Bill_Info/benefits.htm#DEA).

Thinking of this future, I asked Laticia what expectations she has for Derek.

She pursed her lips for a moment, looking to where he sat leaning over the desk between us, filling out the study survey. "I would say definitely the attitude he's maintained the whole way through, to hold on to that. Not to slip into something else. Just maintain himself with the world. Not get – and I don't see this ever happening – not get sucked into the fact that the government's going to [take care of him]… to get sucked into the fact that he can't still be productive. Because it's a part of who he is, already, and if he's going to lose that I don't see him staying true to himself." She sees his ambitions and energy as a vital part of him, and worries that he might fall prey to a notion that – as a wounded veteran, as a veteran with a history of PTSD – he cannot live up to his goals. "And if he's not true to himself, then who else is that going to affect? That's going to affect me, the kids. That's why it's important, because I don't ever see him as someone who just wants to sit and lounge around." Derek gave a small smile over his survey, and from the look that passed between them, it seemed this was a concern she had raised before. "Other than that, he puts really high expectations on himself. He needs no help from me."

Whether at her urging or out of some deeper habit, Derek shows no signs of lowering his aims for himself. There is always, for him, the memory of his deceased father, whose PTSD led to alcohol abuse and abandoning first one family (Derek's) and then another (that of the younger half-brother Derek only recently found out he has). Derek says of dealing with PTSD that, "[My father's] experience actually helps me with that, seeing what it did to him. It helps keep me in the, 'I need to see somebody. I need to get help before it gets to that point.'" He finds a cautionary tale in his father's life. There are other lessons from his childhood that he has also found relevant. He was raised by his mother and grandparents to strive to be the very best,

to be impatient of average standards and to work towards something greater. These lessons have become part of who he is to this day. "I still hold myself to that standard. I expect myself to perform to a higher level."

Ironic as it may seem, some of Derek's confidence may also stem from being wounded.[10] Both Chris and Adam spoke of how much easier they believed it would be if they had a physical wound to mark their suffering, and there may be some truth to this.[11] There is an automatic empathy that many Americans describe feeling when they see a wounded service member, particularly if they believe that wound has been suffered in the act of patriotic service (although this reasoning may prompt complex feelings of admiration, sorrow, and/or dismay). The expectations placed on physically wounded veterans may also be somewhat fewer than those placed on the invisibly wounded. Derek says of his rehabilitation group's regular visits to obstacle courses and other excursions focused on "community integration" that they give wounded veterans an opportunity to prove that, "'Yeah, you may have taken away an arm or whatever, but we can still perform at the level we did.'" Their ability to perform as before is remarkable precisely because it is not expected. Derek is a wonder to sit across the table from

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[10] Zohar and his colleagues have recently debunked the myth that wounded soldiers are less likely to develop PTSD because they have a visible injury and receive more compassion (Zohar, Juven-Wetzler, Myers, & Fostick, 2008). I would still contend, however, that wounded soldiers may find it easier to recover from PTSD, given the additional supports and reduced stigma they face. This question calls for further research.

[11] A recent neuroimaging study found that participants demonstrated a more compassionate response when learning of another person's physical injury than they did when hearing of social or psychological distress. The authors of the study, who included famed neuroscientist Antonio Damasio, found that watching a video of a tennis star breaking her ankle, for example, triggered a stronger response in the brain than did an audiorecording of how cerebral palsy had led a woman to give up hope of ever marrying (Immordino-Yang, McColl, Damasio, & Damasio, 2009). Not only was the compassion response to the second story slower to begin, but it actually triggered a different series of neural pathways than did the tennis injury. In other words, there may be something fundamentally different in the human response to physical vs. emotional pain and suffering.

because – bionic man that he is - he remains so resoundingly undaunted. By contrast, for those whose wounds are internal and unseen, it can be difficult to gauge the visceral reality of what, exactly, they find so daunting. Their failures are likely to be judged more harshly, and their greatest achievements may never appear as impressive as Derek's, simply because he starts with such a visible deficit. (At the same time, it is unavoidably true that Derek starts with a deficit. He is short one leg, and would no doubt be happy to have it back.)

By virtue of being wounded, Derek also has access to the regular inspiration of other wounded veterans in his life. At the Center for the Intrepid, he has something he says is "unique… because by the time I got here it was 2006, so the war had been going on for three years. There were guys who had gotten injured day one [of the war], and guys getting injured still now." PTSD was not an unusual diagnosis among the so-called "Wounded Warriors" at the CFI, and there was a special on-site coordinator dedicated to providing PTSD referrals to these men and women. Those who had been injured earlier and made more progress with their recovery stayed involved with the Center, working to provide a visible example of recovery to the newly wounded, offering a view of what is possible. "We have a progressive cycle – when they were the veterans, they took care of us. They showed us what to do. They held our hands as we filled out the paperwork, and now it's our turn. I did the peer visiting thing and walked around the hospital when the new guys got there and showed them the leg and said, 'This is what I'm doing now.' It helped the family members more than the guys. Just to have that support – to see the guys that have already done it and to know that it's out there."

Along with the support provided by other wounded veterans, Derek has relied heavily on Laticia. Early on, she told him that anything he could do, she would do with him. And so, when Derek learned to ride a bicycle again, she accompanied him in cycling the 75 miles from

San Antonio to Austin. It took them two days, riding 50 miles the first day and 25 the second. They tease each other about what other plans they agree to share; she is willing to ride with him to Corpus Christi (approximately 140 miles), but draws the line at swimming across the San Francisco Bay to Alcatraz.

But when Derek says he could not have made it this far without her, Laticia says, "I didn't feel like I was doing anything that – that's my *husband*. That's my *husband.* That says something. Even though we did it in the courthouse that way, I said I was going to marry him. And that's not just, 'Oh, I really like you a lot…house and home…' It wasn't about that." This has been the vision of marriage she has seen her whole life. "The way I grew up, my mother and father were still together. Even my grandmother and grandfather, even though they fought, they were still together. They always made a way, and I think always making a way… making it seem effortless, do what you need to do."

Even during the early period of his recovery, when Derek was fully dependent on her, "There was never a thought of…," Laticia lets out a big mock sigh, "why did *my* fiancé have to have this happen? That never crossed my mind. It was me taking care of my family. It was me as a wife doing what a wife needs to do to take care of her husband through the sick and the health and the rich and the poor. Period. That's just what you need to do. You get it done. So for him to come home and need help, it wasn't a problem. This is what I need to do."

Derek adds, "And that actually helped me a lot because there were many days when I came home and felt a huge burden. If there was anything that made me depressed it was that – look at all she's doing for me and I can't give it back. I can't give enough back to her to make up for it. That was my little bout of depression and it would come for an hour or two, and that

really helped. She never once said, 'Look what I've done for you,' or 'You're lazy, why can't you do it?' And that helped a lot."

Derek has – in his great journey – been mobilized by many forces. He has been drawn ahead by the vision of other wounded veterans whose recovery and success he has witnessed and shared in. He has been urged on from behind by the memory of his father's struggles, which keep the stakes of this journey ever in mind. He remains beholden to the high standards of achievement instilled in him as a child. His opportunities have been shaped by the healthcare and educational benefits provided to him as a veteran. And he has been accompanied along the way by Laticia, who has in every way gone the distance with him. Like Derek, Laticia draws on the lessons of her past in creating the present, living out the attitudes toward marriage she saw enacted by her parents and grandparents. They have developed a view of PTSD together, in dialogue with each other, with Derek's care providers at BAMC and the VA, and with other wounded veterans. They have derived responses based in their own histories, learned expectations, and their still-under-negotiation hopes for the future. Laticia admits that she cannot always understand Derek's PTSD, but hearing his stories has helped her to better imagine what war must have been like, and in understanding she finds it easier to be patient. Their life is a work in progress, but it is *their* life, plural and shared. PTSD may create dislocation in the social world – it has at times created dislocation in theirs - but the social world may also be a source of healing, the ties that re-bind what was torn asunder.

Individual Maps and Shared Journeys

For every PTSD-diagnosed man in this study, there is a tale to be told of his effort to live with PTSD. For some, the goal is as immediate as treading water, making it through the day.

Life with PTSD may be simply an effort to avoid drowning (picture Chris on his worst days, unable to find a justification for continuing to live). Focusing on short-term goals may allow veterans a period of rest after long effort, or a pause during which to peruse the horizon when unsure of the right direction. Other veterans may have a more long-term vision, complete with future-oriented goals that draw them forward – a college degree, a career, starting a family. Goals may be strongly felt at one point in the journey, less so at others. Meanwhile, the intensity of trauma-related distress varies greatly among individuals and over time, adding storminess to the waters.

For every veteran with PTSD, the story of living with traumatic illness looks different, uniquely shaped by their own individual life experiences and trajectories, the social networks of family and friends whose understandings of life, war, and suffering help to shape their worlds, and the local American ethnic and military cultures that encourage them to behave as men in certain ways. They also encounter many shared cultural pressures, obstacles, and opportunities. These include the economic disparities that pattern military recruiting and thus determine who is sent to war, political controversies over veterans' healthcare and benefits, the social history of past wars and past veterans, lay and professional understandings of PTSD illness, the institutional structures of the military and of mental health care within the VA, and the ambivalence with which returning warriors are greeted in American society.

Each individual veteran's course represents some unique attempt to navigate a collision of these forces, these layers of cultural experience. Even among such a similar group of veterans as is presented by Chris, Adam, and Derek – each has PTSD following a series of traumatic events that took place during combat, each accepts his PTSD diagnosis, each has sought professional mental health treatment at one particular VA – the narratives veterans tell

of their experiences are highly individual. Chris' story reveals how idiosyncratic models of PTSD may rely on notions of cause and effect that are in themselves contradictory, reflecting the input of widely varying notions about what PTSD is. Adam's story reveals how a trajectory may be shaped by experiences along the way; his initial experiences with military healthcare and PTSD treatment were negative, and he has retained his suspicion of institutional responses to veterans' needs as he has moved forward despite other, more positive encounters. All three veterans demonstrate how veterans acquire their understandings of PTSD and embark upon certain responses in dialogue with others in their lives – in particular, with clinicians, spouses, and other veterans.

Each of these three examples reveal, moreover, how an individual's way of talking about PTSD may – even as they stem from a shared idea of PTSD illness – reflect his or her own particular struggle. Chris, describing PTSD, calls it a result of "not dealing with stuff that's extreme, and how you were involved in that extreme situation." For him, PTSD has resulted from the horror of what he saw, but also his concerns about how he engaged in combat. He is horrified to remember that he pissed himself under fire, and that he was unable to fire his gun his first time in a firefight. Adam, by contrast, calls PTSD a "failure to reintegrate." His concerns are not so much with combat itself, but he has found the home-coming to be something of a challenge; he has not wanted to give up his warrior identity and exchange "camos" [a camouflage uniform] for "civvies" [civilian clothes]. For Laticia, whose understanding of PTSD has largely been acquired secondhand through Derek (reporting on the messages he received from Dr. Richardson), PTSD results from "being in an intense and stressful, dangerous environment over a long period of time." In deriving a response to Derek's symptoms, she places her focus on the suffering that caused him to be this way. What he is, he is because of

what he has been through. So it is that Chris locates the problem in combat and Adam in homecoming, and Laticia focuses not on the problem at all but on the honorable suffering that was its cause.

With so much at stake – under the weight of cultural expectations and working within the limitations imposed by social, financial, and institutional constraints – these individual models of PTSD become more than simply an (albeit vital) exercise in meaning-making; they serve, too, as maps, charting possible paths for interpretation and response. Each of these individuals has derived his or her understanding of PTSD and attempt to navigate it from amidst the many available messages around PTSD illness, veterans, and manhood in contemporary American life. Adam accepts his diagnosis, but, like Chris, still views it as a "weakness." He has forged a response from within the politicized discourse of veterans' rights, re-imagining himself as an advocate working to support other veterans in their battles with the VA and with post-war life more generally. Chris has struggled with distress stemming not only from his PTSD, but also from his desire to keep "moving up," to make gains in his career and lifestyle that appear acceptable to both his peers and himself. Derek took on PTSD treatment just as he took on rehabilitation after his leg was amputated ("Let's figure out what the plan is now"), urged on by the cautionary tale of his Vietnam veteran father's PTSD-driven slide into substance abuse and an early death. Laticia hints at the vague worry that Derek will fall back on the government support provided to him as a disabled veteran, but trusts, too, that Derek will be "true to himself" and move toward a career- and family-driven future. In building their distinctive interpretations and understandings of PTSD, all of these individuals have also created maps for how they imagine the future, and for their own selves and actions in working toward this future.

These maps propose hypothetical answers to essential questions: what will happen to me? To my family? To my goals for a good life?

Desire and Identity

Anthropologists, so well-equipped to describe cultural beliefs and institutions, have often struggled with the task of explaining how humans behave in and amongst all that culture. Even in the days when culture could be observed in isolated communities that were more homogenous than any community in our current age of globalization and hypermedia, it was never true that individuals all behaved the same way. Culture might create a shared ideal for behavior – a shared template for responding to challenges like those posed by illness and suffering – but it has never succeeded in making humans predictable.

One of the richer metaphors for describing how humans build a life thus "with and against culture" has been offered by Sherry Ortner, with her notion of "serious games".[12] She points out the importance of individual purpose and desire in influencing how a person behaves. She emphasizes the place of cultural symbols and ideals in shaping those desires. She recognizes, too, the role of what she calls "material necessity" and what I have been calling "political economy" – in other words, the financial and material resources of life and the political structures that control access to them – in closing or creating opportunities. In the image of serious games, she writes that she means to suggest:

> …that people do not just enact either material necessity or cultural scripts but live life with (often intense) purpose and intention; that people are defined and redefined by their social and cultural contexts, which frame not only the resources they start with but the intentions and purposes they bring to the games of life; that social life is precisely

[12] (Sherry B. Ortner, 1999)

> social, a matter of relationships – of cooperation and competition, of solidarity and exploitation, of allying and betraying. (23)

In calling such games serious, she further points out how much is at stake in many of the interactions of daily life. She emphasizes the role of history and power in shaping the games that people play, and, in turn, writes of how people themselves make history with their actions, challenging and resisting power when the opportunity arises.

The metaphor of navigation that I have offered here is not unlike Ortner's notion of serious games. Navigation is simply the process of living with and against culture amidst profound distress. Ortner's particular insight is, I think, in recognizing the importance of desire in shaping how humans move through life, and with what intentions. Among this group of veterans, it became vividly apparent that the power of cultural expectations to shape individual action is mediated by desire. So much of this discussion of PTSD has been focused on failure – the failure to reintegrate, the failure to succeed – and there can be no failure without desire.

This may be the last and most important way in which culture shapes veterans' experiences of PTSD, by influencing their desire for those larger life goals with which it may interfere. These veterans are American men, and I have attempted to demonstrate that their goals are fully in line with normative priorities for men in contemporary American culture: marriage; fatherhood; career success; the admiration of family, community, and peers. But they are also combat veterans, and they bear the added burden of creating a post-war life that can live up to the intensity of their past experiences. They desire an identity that lives up to cultural expectations without doing any disservice to the men they became during war – men who they often see, at least in retrospect, as being the bravest, most heroic version of themselves. This may be particularly true for those who joined the military young enough that they had little time

to develop an adult identity other than that learned in the service. We saw this with Chris and Adam, both of whom spoke of their time at war as the pinnacle of their lives.

To give one last example, Hector was, in his late 40s, among the older Iraq veterans who participated in the study, on the tail end of a 25 year Army career. He came to the hospital for our interview straight from the gym, sweaty and wearing a grey t-shirt that read, "Life without MOBILIZATION – I don't think so!" His hair, cropped short on the sides, had grown too long on top, a neglected high-and-tight. I was unsure whether to believe him at first when he told me that he had been a Major in the Army. He slouched too far in his chair, looked too unkempt and bedraggled. Nothing in his appearance or manner of speaking – slow, deliberate, rarely making eye contact and then, when he did so, staring me aggressively in the face – fit with my experience of Army officers (who I have generally found to be good-humored and well-spoken). We spoke for nearly four hours that day, largely because he insisted on telling extended stories of his time in Iraq, slowly and entirely, conveying every nuance and pause in a given conversation. He referred constantly to having seen combat and told me several times, rather dismissively, that it was impossible for anyone who hasn't "seen the elephant" [been in combat] to understand what it is like. And yet, relentlessly and despite his own better judgment, he kept trying to tell me what it had been like, as though he could wear down my ignorance under the sheer volume of his words.

Several times in our conversation, Hector mentioned a photograph of himself that he had found online. It was taken during his time in Iraq, and captures him in the middle of a hectic workday, overseeing the implementation of a new data security initiative for the Iraqi government. In describing his struggles with post-deployment life, he kept returning to this image of himself, which he described with a proud and wistful little smile. He admitted frankly

that Iraq had been the highpoint of his life, and that he was struggling to make a life he could live with following his retirement from the Army and the end of his military career. As a middle-aged man, he felt he was too old to start over and too young to retire. He was not married and had no close family, although he described a handful of close male and female friends from the Army. What he did have was that photograph, that tangible proof that he had been and done something great.

When I returned home after the interview, I Googled his name and the picture came up almost immediately. In the photo, he stands looking over the shoulder of a young woman soldier at some piece of paperwork she is holding. He is focused, intent on the task. He looks like the cool, calm center of a whirlwind, the very image of a dependable leader. He is, in this picture, almost unrecognizable from the man who had sat talking in the chair across from me. The man in the chair knew this. He was trying to get back to that best possible version of himself. This was his strongest desire.

The Social Life of PTSD

Beyond identity, there was one additional aspect of veterans' desire that was as important, if not more so, and that was the impetus to maintain key social relationships, whether with spouses or other romantic partners, with other veterans, with children and family, and so on. Even when I went looking for institutions and political economy, for culture writ large, I found myself running again and again into the social relationships that gave meaning and importance to these entities for the men in the study. Veterans' experiences with PTSD have proven to be impossible to understand without an appreciation for the social contexts in which they are lived out.

For little boys grow up to be soldiers amidst family traditions that value military service, eagerly showing off their new uniforms to family and friends whose opinion they value. Trauma is itself embedded in human relationships. Many of the trauma stories told by the men in this study were described as traumatic precisely because the events resulted in the injury or death of close friends, or because those damaged bore too much resemblance to loved ones outside the war zone (as with Jesse and the Iraqi child who reminded him of his nieces and nephews).[13] Sleep disruption and nightmares are troubling occurrences in the period of time after the return from deployment, but they remain far less devastating that the feeling of social isolation and dislocation from family and friends. Veterans with PTSD face the responses of family members and their peers and leadership in the military uncertain as to whether their distress will be met with stigma or empathy. These fears of negative judgment, too often realized, affect how they name their troubles and seek care. PTSD treatment at the VA is sufficiently controversial that it creates a highly politicized environment, but it is within the therapeutic relationship between veterans and clinicians that Chris and Derek found what healing they have. Veterans navigate the moral experience of PTSD in watching, learning from, and negotiating with other veterans, family members, and partners, and call upon these intimate ties in traversing their moments of most profound crisis.

PTSD is an illness that is socially constructed and socially contested – an illness that has taken on a life of its own, spreading far beyond the definitions initially given it by the American Psychiatric Association. Perhaps more importantly, however, much of the distress caused by PTSD results from how the illness interferes with social relationships. It creates dislocation

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[13] Charuvastra and Cloitre (2008) have recently reviewed the evidence and come to the conclusion that interpersonal traumas are among the most severe and most likely to result in PTSD.

between veterans and their loved ones, challenging men's ability to meet cultural expectations and thereby to maintain the very networks they value most. As Juanito the Marine put it – he who returned from the war to live alone in an empty apartment, unfurnished but for a mattress, a television, and his duffel bag – "it sucks to be alone. Family, friends, the relationships you make are really important to have a good life." PTSD too often puts a strain on key relationships, and in doing so, makes it harder to have a good life.

PTSD is also social in that it creates distress far beyond the individual. There was no PTSD-diagnosed veteran in this study whose illness affected only himself – always there were children, girlfriends, wives, parents, or friends whose lives were also affected, if only by the veteran's absence as he succumbed to the desire to isolate himself. There is a growing acknowledgement of the way that PTSD-related suffering ripples outwards, not only through isolation and withdrawal but also through divorce, substance abuse, interpersonal violence, homelessness, and suicide. Melissa (of Chapter Eight) was not the only one of the wives interviewed who had developed PTSD from her husband's violence against her. Following his arrest, their youngest child was removed from the home by protective services, who feared for the little boy's safety. Such events have the makings of a tragedy that is, once set in motion, difficult to avert.

It is nothing new to say that suffering is a social process or event (there is even a subset of theory in medical anthropology related to "social suffering").[14] But this is again where culture meets PTSD. For the desire to maintain these social relationships is a powerful mechanism by which cultural expectations are enforced in daily life. It is one thing to buck a trend in the

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[14] (Das, Kleinman, Lock, Ramphele, & Reynolds, 2001; Das, Kleinman, Ramphele, & Reynolds, 2000; Kleinman, Das, & Lock, 1997b)

abstract – for example, for a soldier to say to himself, “To hell with weakness, I need help” – and something very different for that same soldier to face distance and disgust in the eyes of his best friend upon making such a statement. Chris worried, years after the last time he had seen him, what his friend Brent might think of his PTSD diagnosis. Brent’s imagined judgment remained a set of expectations against which Chris continued to judge himself, because of the importance of that relationship in his life. It is in this way that culture is embodied in the real and imagined desires of the people we see and know and love, and it is in this way that their desires become our own. It is in this way that the distress caused by PTSD is unavoidably bound within a veteran’s social and cultural networks.

At the same time, however, it is within these same social relationships that many veterans find the way to navigate their distress and create resilience. Derek never describes PTSD as a weakness or in any way shameful, the way that both Chris and Adam do. This may be in part because of the extended period of time required for his physical rehabilitation, during which he remained surrounded by other wounded veterans. He was thus given the opportunity to re-imagine himself in an environment where PTSD may have been more generally accepted as a consequence of heroic service. In addition, he had the benefit of a wife who believes that his suffering has, alongside the difficulties it has created, made him a more loving and compassionate individual. Contrast this view with Chris’ inability to convince his wife that PTSD is more than simply an excuse he uses to justify other inadequacies. The combination of other veterans’ tolerant attitudes and his wife’s support were not enough to protect Derek from developing PTSD, for he spent months on patrol in a combat zone and faced repeated trauma and loss. But they likely made it easier for him to identify the problem and to seek care with

minimal ambivalence, care that he then found to be transformational in improving the quality of his life.

It is encouraging, therefore, to see that there is growing recognition of the importance of social processes and relationships in shaping PTSD among clinicians (including those who participated in this study) and researchers.[15] In 2008, researchers at New York University's Institute for Trauma and Resilience went so far as to call for developing a "social ecology of PTSD," arguing for the clinical importance of "understanding how both PTSD risk and recovery

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[15] The impact of social relationships on health is also an area of increasing focus in psychological and epidemiological research more generally. Studies conducted over the past several decades point to an important role for social relationships in shaping morbidity and mortality across the life span (Teresa E. Seeman, 1996; Teresa E. Seeman & Crimmins, 2001). Social integration has been associated with decreased mortality by coronary heart disease independent of other risk factors (Orth-Somer, Rosengren, & Wilhelmsen, 1993; Vogt & al, 1992). Social integration and support have also been associated with differential disease severity, as in studies showing an inverse association between instrumental and emotional support and the extent of coronary atherosclerosis (Blumenthal & al, 1987; T.E. Seeman & Syme, 1987), and linking social integration to improved recovery outcomes following myocardial infarction and stroke (Berkman, Leo-Summers, & Horwitz, 1992; Colantonio, Kasl, & Ostfeld, 1992; Ruberman & al, 1984). Social ties have also been found to affect mental health outcomes, with a number of studies identifying a protective effort for social support in preventing depression (George, 1989) and post-traumatic stress disorder (PTSD) (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

There is, however, a growing appreciation for the complexity of the relationship between sociality and health, as it has become clear that, while positive aspects of social relationships may have a protective health effect, negative aspects of social relationships may have a counterposed detrimental effect on health (Abbey, Abramis, & Caplan, 1985; Burg & Seeman, 1994; Schuster, Kessler, & Aseltine, 1990), particularly in relationships characterized by criticism, conflict, and demands for assistance (R.C. Kessler, McLeod, & Wethington, 1985). Moreover, positive and negative aspects of social ties appear to occur independently of one another (Finch, Okun, Barrera, Zautra, & Reich, 1989; Schuster, et al., 1990), suggesting that their effects may not be mutually exclusive and should be separately accounted for. Although the mechanisms by which social relationships may affect physical and mental health remain understudied, Seeman & Crimmins (2001) point out that the two most promising pathways appear to be: a) via the social learning influence of family, peers, and other members of the social environment on health behaviors; and b) via a direct impact of social relationships on physiological states and mechanisms, such as immune function and neuroendocrine activity.

are highly dependent on social phenomena."[16] Based upon the findings of the PDS study, I have recently been involved in the formulation of a VA study that will further explore the role of veterans' relationships in shaping their physical and psychological health over time, assessing associations between interpersonal relationships, resilient coping strategies, and long-term morbidity and mortality. More and more individuals involved in coordinating clinical and policy-level responses to PTSD are beginning to appreciate the importance of including families in treatment, in working to combat stigma, and in helping veterans to negotiate the social challenges of living with PTSD. There is much yet to learn and discover.

[16] (Charuvastra & Cloitre, 2008)

Conclusion

Recommendations for a Focus on Resilience

Chapter Ten

In the Preface with which this dissertation began, I suggested that PTSD is best approached via a series of stories being told about war and its aftermath in contemporary America. In the intervening chapters, I have described the stories that PTSD-diagnosed veterans tell of how they came to the military, of combat, of coming home from war to find themselves changed, of struggling to make sense of their distress and to take action in response to it. These stories have proven to be both cultural and personal. Although the twin focal points of the dissertation are personal experience and cultural politics, it should be abundantly clear by now that one cannot separate the two. Combat trauma (the personal) may occur during war (the political), but is unavoidably shaped by the meaning of the event to the individual (the personal), a meaning that is partly the product of a shared vocabulary for describing experience (the cultural). And so on.

Along the way, I have suggested that it is impossible to comprehend PTSD as either an experience or a cultural product without stopping to appreciate the stories that become labeled

as traumas (Jesse's Iraqi child), as well as many of the stories that do not (Brian's burying the dead in the first Gulf War). I have presented PDS study findings that reiterate the results of many other studies, showing that combat trauma is only one of many kinds of experience (such as Tony's childhood exposure to family violence) that may cumulatively increase the risk of developing PTSD. Post-deployment knocks – the inability to reintegrate into family and community life, divorce, unemployment, and so forth – may also play a role in exacerbating PTSD risk among recent veterans. When veterans return from war to find that what they thought would be a chance to create new post-combat lives is, in fact, far more challenging than they ever imagined – when they find themselves dislocated from their loved ones and struggling to meet their most basic expectations for self and life – these challenges make it far more difficult to muster a resilient response to the trauma of war. Thus, the aftermath of combat trauma cannot be understood without an appreciation for the larger life course of the individual veteran.

Nor is it enough to appreciate that veterans' vulnerability to the lingering effects of trauma may be profoundly shaped by their experiences of readjustment. Post-deployment experiences are also inexorably influenced by the way that veterans and those in their social worlds interpret and respond to the problems created by PTSD. It is one thing for a veteran and his loved ones to presume that nightmares and aggressiveness are a natural part of the return from combat; he may then see these phenomena as part of a warrior's noble burden, name them PTSD, and seek treatment without shame. It is another thing entirely if the veteran returns home and judges his distress as a sign of weakness, or meets such judgment in the eyes of his family and friends. Then PTSD may become a hard diagnosis to reach out for and accept ("It just seems weak"), or – alternatively – may become the acknowledgement that enables a

veteran to live with himself ("I thought I was the only one"). Powerful and deep-seated, these interpretations and reactions are rooted in American cultural ideas about trauma-related suffering and mental illness, and in highly gendered expectations for male emotion and behavior.

Moreover, the perspectives on combat PTSD that veterans run across may be complex and contradictory, shading from stigma to acceptance and back again as veterans move across social settings.[17] The U.S. military has – under the logistical influence of needing to retain as many healthy service members as possible in a time of war, and under pressure from public opinion and national media to demonstrate due concern for troops' well-being – instituted a variety of measures aimed at easing the experience of readjustment and providing prompt and effective treatment for service members dealing with PTSD. While the military's efforts have been prodigious, they have at times run up against opposing messages deeply rooted in military culture and war-time necessity. The military has spent decades creating a structure of ongoing socialization that instructs its members in the masculine values of toughness, stamina, and invincibility, and that rewards those who push past their own limits to become cool and composed under fire. These values are passed on in the relationships between service

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[17] Readers familiar with Unni Wikan's essential (1990) Managing Turbulent Hearts: A Balinese Formula for Living will recognize the underlying influence of her theory of "criss-crossings", describing how individuals shift their performances of self as they move across physical and social space. She notes that individuals adjust their performance across social settings – presenting themselves differently within the home, for example, than they may in the street – but that the requirements of each setting are a reflection most importantly of the other people present. Neighbors present within the home, therefore, may transform even "home" space into "street" space, although this will depend at least in part on the characteristics of the relationships between neighbors. Thus she demonstrates that self-performance, a necessary component of working to meet cultural expectations, is profoundly shaped by social relationships, imagined judgements, and the social creation of physical space. This is certainly true for veterans, whose physical moves across the spaces of home and family, the military, and the VA are profoundly social in their implications.

members, and, in a time of war, reinforced further by the pressures of combat, when every unit member is encouraged to believe that group survival depends upon his living up to his obligations. Faced with the lasting power of these lessons, even the best efforts of military leadership have often proven inadequate to uproot stigmatizing ideas about PTSD. Too many service members have found themselves caught between conflicting messages: "We can help!" they hear, and also, "If you're broke, we'll kick you to the curb."

Amidst this muddled scenario, official protocols for prevention and treatment in the military are inconsistently enforced, and service members may find themselves torn between differing sets of needs and expectations. This is how Chris found himself drinking into a three-year decline, punctuated by arrests and pats on the back ("He's a combat vet. We don't mess with him…"), before ending up under personal escort on a plane back to the States, locked down in a psychiatric ward while the paperwork was filed for his early retirement. This is how the Army Chaplain (described in Chapter Five) found himself standing in an on-base hallway, outlining months of distress to me in a few moments of hushed conversation, seeking acknowledgement while watching out to make sure no one else was listening.

PTSD has taken on a wholly different set of meanings in the public fora of history, media, and national obligation. Within highly politicized debates around the role of the U.S. Department of Veterans' Affairs, PTSD has become associated with the abandonment of Vietnam veterans a generation ago, and with the VA's past and present failures to provide adequate benefits and healthcare. Veterans, politicians, veterans' advocates and VA clinicians all move together within this social and historical milieu, coming together in a convoluted dance to negotiate and provide what is thought to be needed, whether disability pay, PTSD treatment of one kind or another, or symbolic acknowledgement of veterans' service and sacrifice. Against

this backdrop, mental health clinicians conduct their own negotiations at the VA, initiating a slow shift in PTSD treatment paradigms that may, over the coming decades, have radical implications for how PTSD is popularly and professionally understood, shifting the model from one of chronic suffering to one of recovery and resilience. If successful, their gamble may prove to have ripple effects far beyond the clinic, reverberating in both the political debate over veterans' disability compensation and the personal space of veterans' lives.

PTSD, thus, is an idea in flux, beholden to different meanings and concerns depending on the settings and stakeholders involved: within the military as opposed to the VA, for service members as opposed to veterans, for veterans as opposed to clinicians.

Meanwhile, I have argued that veterans' experiences of PTSD – and the decisions they make about such essential questions as whether or not to identify with the disorder, to seek out disability compensation, to attend VA or other treatment, etc. – are influenced by concerns that are not only sociocultural, historic, and political/economic, but also deeply moral. Veterans are the subject of significant ambivalence in American life, summoning up an image of both noble service and heart-wrenching sacrifice. They are thought worthy of respect and yet also somehow tainted, made frightening by the violence they are imagined to have witnessed and wrought. Although this ambivalence is rarely spoken of, veterans are themselves aware of it and may find themselves making choices subtly shaped by the desire to prove themselves. PTSD carries its own such burdens, prompting responses of both great pity ("They're sorry I had to go through that") and great fear ("You're not going to kill me, are you?"). For a minority of veterans, PTSD has become the diagnosis they blame for the violence that has erupted in their intimate relationships, while also emerging as the rationale that makes that violence forgivable – regretted but still morally manageable.

Finally, there are immense cultural expectations placed on all returning male veterans to fulfill their roles as men, as partners, as fathers, as participants in the work force, even as veterans. And it is not only these expectations that are so vital, but *veterans' own desire to live up to them*, because of the social bonds retained if such roles are performed successfully, and the social consequences if left unfulfilled. Study participants who were less confident in their ability to live up to adult male role expectations also reported receiving less social support from their families and friends. There are consequences in failing to live up, and perhaps no consequence is harder for social beings to bear than the loss or slippage of personal relationships.

It is in these interactions between veterans and their social worlds, too, that the dialectic between the personal and the cultural/political is played out. Individual veterans' experiences of PTSD are shared with family and friends. Stories are passed around, through social networks and the media, and may at times become cautionary tales of what can go wrong for new veterans. These cautionary tales, in turn, become part of the cultural interpretation of PTSD, informing public understandings of what distress signifies PTSD, what the likely course of the illness will be, and what responses are most appropriate (whether care-seeking or stigma or suffering in silence). These expectations become part of veterans' lives, communicated in print and on TV and in the spoken and unspoken messages of daily interaction.

These, then, are the fields of combat, the messy and shifting grounds on which PTSD-diagnosed veterans must navigate. And the stakes are high. Their distress is real and palpable. Suicide is frighteningly common. I conclude now with the central question of what combat PTSD is and what challenges it will present for U.S. veterans, their families, and the nation over the coming decades.

Defining PTSD

In the face of such suffering, it should come as no surprise that PTSD can be hard to pin down as one thing or another: a mental illness related to psychological mechanisms of avoidance and adaptation; a loss of innocence; a normal experience of terrible grief at witnessing horror and injustice.[18] All of these are perfectly plausible ways of understanding PTSD.

There is, in other words, no single answer to the question of what PTSD is. There may be a clinical definition written in the pages of the DSM-IV, but that definition becomes something far more slippery when it passes out into the world, diagnosed and lived out and claimed and apologized for and made real in the discourses and engagements of everyday life.

In recent months, when I have discussed the findings of this study with anthropologists, they have often asked – with an air of gentle foot-tapping, as if to say, "let's get to the crux of this now, shall we?" – whether or not I think PTSD exists. At first glance, this seems like a rather simple question: of course it exists. Thousands of veterans have been diagnosed with it. It is described in the pages of the DSM and hundreds of other books have been written about it. Hospitals have entire clinical programs devoted to it, and there are national laws and policies devoted to deciding when and under what circumstances it is appropriate to provide compensation for it. Around the world, hundreds of thousands of individuals have been diagnosed with PTSD following combat, rape, torture, motor vehicle accidents, acts of terrorism, and other traumas. PTSD has become a dominant way of describing the psychological aftermath of trauma worldwide. So why would anyone ask whether it exists?

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[18] (Gutmann & Lutz, 2009)

But this isn't exactly the question being posed. The question is – more accurately put – something like, "do you believe that PTSD is a universal human phenomenon, or is it simply a cultural model Americans have cooked up to describe certain kinds of suffering, a model that then managed to catch on in much of the rest of the world?" This question is actually a very good one, and stems from the nature of the conversation that has gone on around PTSD within the social sciences. As I've mentioned before, Allan Young's critique of the diagnosis in the mid-1990s kicked off this debate, but it has since been taken up by other scholars exploring trauma and trauma treatment programs around the world. In his initial work, Young suggested that PTSD was largely a construct in which common psychiatric symptoms were clumped together and given a new name for a variety of reasons – to provide compensation for disenfranchised veterans, to appease an American conscience uneasy with the then-recent memory of Vietnam, and in accordance with a view of traumatic memory developed within professional psychiatry. He argued, essentially, that the diagnosis was less a product of scientific observation than of cultural process. In Young's view, PTSD was an illness construct brought to life by clinicians in the very practices of the clinic, rather than a phenomenon describing a cross-culturally available response to trauma.[19]

Young's critique of PTSD has been built upon by other clinicians and researchers. Derek Summerfield, an influential researcher in the U.K., has argued that PTSD is a Western biomedical construct that has unclear relevance and meaning in non-Western cultures. Observing PTSD among a wide variety of groups around the world – refugees, victims of genocide, etc., - he

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[19] Cross-culturally *available* because, of course, most people exposed to trauma do not develop PTSD. PTSD appears to be a *possible* outcome of trauma exposure in all parts of the world, but it cannot rightly be said to be universal because only a minority of people ever show signs of it.

contends that PTSD focuses rather arbitrarily on trauma as the essential cause for psychological distress, when a number of other causes, such as poverty, might suit just as well.[20] Others have argued that focusing too closely on PTSD distracts attention from the needs of those with other psychiatric disorders, or that it locates trauma within the individual, thereby removing focus from upstream causes of trauma – such as social inequality, war, the greed of nations[21] – and from the most likely source of cure – reestablishing social relations.[22,23] Much concern has been expressed about the "medicalization" of trauma, the idea that trauma indicates something wrong with the individual rather than with the society that produced or allowed violence in the first place.[24]

PTSD has also been the subject of considerable examination by those working in cross-cultural settings. Many of these authors have expressed concern that perhaps locally-specific ways of describing trauma might be of more use to, say, Sudanese refugees living in a camp in Kenya, than are a set of symptoms and criteria originally identified among combat veterans in the U.S. A number of studies have provided important answers to this question by examining how individuals who appear to be struggling in the aftermath of trauma *manifest* such struggles in non-Western contexts.[25] The results have generally found that some subset of any given population exposed to trauma will exhibit symptoms of PTSD. They may be more likely to

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[20] (D. Summerfield, 2000; Derek Summerfield, 2000b)
[21] (Silove, 2005)
[22] (Englund, 1998a)
[23] A larger part of the anthropological work related to trauma, of course, has focused on trauma and suffering themselves rather than PTSD specifically (e.g. Bourdieu & Accardo, 1999; Das, et al., 2001; Das, et al., 2000; Fassin & d'Halluin, 2007; Henry, 2006; Kleinman & Desjarlais, 1995; McKinney, 2007; Robben & Suarez-Orozco, 2000; Zarowsky, 2004).
[24] (Kleinman, 1995)
[25] (e.g. Cardozo, Talley, Burton, & Crawford, 2004; Hinton, Chhean, Pich, Pollack, et al., 2006; Hinton, Hsia, Um, & Otto, 2003; Monmartin, Silove, Manicavasagar, & Steel, 2003; Van Ommeren, et al., 2001)

exhibit some symptoms than others, and may *also* exhibit symptoms that are more in line with local ways of expressing distress.[26] For example, psychiatrist Devon Hinton and his colleagues have found that a significant number of traumatized Cambodian refugees meet diagnostic criteria for PTSD (56% of those reporting to a psychiatry clinic, in one study)[27], but may also exhibit more culturally-specific symptoms such as sleep paralysis, tinnitus, and neck-focused symptoms.[28]

All together, these studies demonstrate that, even in settings where traumatized individuals have not been exposed to Western notions of trauma or PTSD, a subset of people are likely to show signs of hyperarousal, hypervigilance, and avoidance. In other words, PTSD may manifest somewhat differently in different cultural settings, but there does appear to be a core shared phenomenon around the globe. Trauma changes the way that some people experience themselves and the world around them, and, in doing so, interferes with their ability to live a happy and fruitful life. [29,30]

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[26] I.e. idioms of distress (Nichter, 1981; Rechtman, 2000).
[27] (Hinton, Chhean, Pich, Pollack, et al., 2006)
[2828] (Hinton, Chhean, Pich, Hofmann, & Barlow, 2006; Hinton, Pich, Chhean, Pollack, & McNally, 2005)
[29] (e.g. Bremner, Southwick, Johnson, Yehuda, & Charney, 1993; Bremner & Vermetten, 2001; Charney, 2004; De Jong, 2005; Fontana & Rosenheck, 1994; Konner, Draft; Yehuda, 2002a; Yehuda, Golier, Halligan, & Harvey, 2004; Yehuda, Resnick, Kahana, & Giller, 1993).
[30] This portrait of PTSD as an illness that has both shared and more specific individual- or group-level facets is entirely consistent with my own experience of PTSD-diagnosed veterans. Tanya Luhrmann has written about how many psychiatrists describe the "feel" of a patient's illness, and may be able to diagnose a patient's illness on sight, without having yet gone through the diagnostic interview. She rightly notes that this ability may be the outcome of a particular learning trajectory (learning to see people in terms of diagnostic categories) rather than necessarily providing evidence that the diagnoses themselves reflect valid differences between one mental illness and another. However, I too found, in interviewing the men of this study, that there was a very different *feel* in being around those who had a PTSD diagnosis as opposed to those who did not. Not only did the veterans with PTSD (as opposed to those who were functioning well or who were troubled by other diagnoses) describe a core set of shared experiences – anger, nightmare, sleep disturbance, withdrawal, etc. – they also presented themselves with a palpable reserve, a perceptible hesitation, a heightened responsiveness to the world around them. These physical cues were extremely subtle, nothing like the level of agitation and jumpiness with which PTSD often

A rapidly growing scientific literature on PTSD reveals that the mechanisms for this change involve interactions between a variety of social, cultural, biological, and psychological factors, although the specifics of these interactions remain clear only in their broadest outlines.[31] For example, although it is widely agreed that parental PTSD increases the likelihood of PTSD among offspring, there appear to be a variety of pathways by which this occurs. A parent with PTSD is likely to pass on certain patterns of hypervigilant behavior and attitudes about the safety of the world to his or her children. A PTSD-diagnosed parent may also pass on a genetic predisposition to the disorder, so that offspring who are exposed to traumatic events may be more likely to develop PTSD. Recent work by Rachel Yehuda and colleagues also suggests that there may be epigenetic factors involved in shaping PTSD risk. They recently published research suggesting that a mother's PTSD may contribute heavily to shaping a child's risk, because endocrine conditions in the mother's body during pregnancy influence the developing fetus' physical and emotional responsiveness to environmental stimuli.[32]

This dissertation has focused on social and cultural factors related to PTSD risk and recovery in returning veterans, but this should not be taken as a dismissal of the role of physiological pathways in shaping PTSD. On the contrary, I think the clinical and scientific research being conducted on PTSD is of utmost importance, and has the potential to greatly

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seems to be portrayed in films. But they were there. Over time, I found that I could identify these signs among individuals I met in settings outside the clinic, developing a fairly reliable radar for who – among a given crowd of veterans and non-veterans alike – is most likely to approach me with a story of their own trauma and PTSD. It is certainly fair to critique this "sense" as proof of my own biomedical enculturation, a culturally produced "instinct" developed by working in clinical settings over time. Nonetheless, it is a sense that I have acquired without any of the clinical training that Luhrmann describes.

[31] (e.g. Bremner, et al., 1993; Bremner & Vermetten, 2001; Charney, 2004; De Jong, 2005; Fontana & Rosenheck, 1994; Konner, Draft; Yehuda, 2002a; Yehuda, et al., 2004; Yehuda, et al., 1993)
[32] (Yehuda, Bell, Bierer, & Schmeidler, 2008)

inform broader understandings of how the human body and mind respond to stress and threat in the environment. Chris, for example, spoke of urinating on himself when first under fire in Afghanistan. This is not an uncommon response to the first time in combat – nor is it an uncommon response to threat across the animal world[33] – but still, not everyone experiences such a profound physiological response to conditions of extreme threat. There is great individual variety in such responses, and much of this variety is driven by the sort of physiological differences currently under scientific exploration. I remain convinced, however, that these explorations remain incomplete without an appreciation for how culture shapes both the environment (e.g. combat, life in the military, gendered role expectations) and the individual response to it (e.g. by experiencing anxiety and thinking of it as 'weakness').

Ronald Simons' work on startle responses, for example, provides a case study of how the simultaneous analysis of both cultural and biological factors can result in key insights into the workings of human illness. Simons has spent much of his career studying startle syndromes around the world, focusing in particular on the phenomenon of *latah* in Malaysia.[34] *Latah* is a condition that occurs among those who naturally startle more actively than others, perhaps jumping visibly at unexpected noises when those around them might only look up. *Latah*, however, also provides a sort of game for Malaysian villagers, who may – upon noticing that someone has a stronger than usual startle reaction – begin startling that individual again and again over time, sneaking up behind him or her and setting off loud noises or giving a sudden poke or strike. Over time, the *latah* (for the term describes both the condition and the person who has it) develops more and more extreme startle responses. Although both men and

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[33] (Sapolsky, 1998)
[34] (R. C. Simons, 1996)

women may become *latah*, the vast majority of *latahs* are women, for the simple reason that villagers are more likely to go around startling women than they are men. Villagers explained this difference to Simons by saying that men might be more likely to become angry and strike back. And so it is that a basically physiological experience – an unusually strong startle response – becomes culturally elaborated, named and subject to local norms for gender and behavior. It may even be that a *latah*'s increasingly violent responses have some basis in the individual's understanding of what it means to be *latah*. Would the *latah* startle quite so dramatically if she weren't expecting/expected to?

Similarly, it remains true that veterans who describe shared experiences of PTSD – even among those who may claim not to have known about PTSD symptoms – may do so based on communicated ideas about what PTSD is supposed to look like, whether consciously or unconsciously. A psychiatrist I know who was trained on the East Coast remembers hearing a story during medical school about how, in the early days of PTSD research, a VA hospital in Washington, D.C. began to see a record number of veterans walking in with blankets slung over their shoulders. One of the doctors at the hospital became so curious about this that he finally asked one of the blanket-wielding veterans, "Excuse me, but may I ask why you're carrying that blanket?" "It's my survival quilt," the man replied. This rather odd response failed to settle the doctor's mind until he heard from a colleague about a new study on PTSD being conducted at the hospital. Fliers for the study had been printed up and requested the participation of veterans who felt they had, among other things, "survivor guilt." Only there had been a typo, and "guilt" was spelt "quilt." Hence the blankets.

The point of the story is supposed to be that these veterans were faking what they thought was a PTSD symptom because they wanted to be identified with PTSD (either to

participate in the study or for some other reason). This story is probably apocryphal, and the fact that this psychiatrist heard it in medical school says as much about the nature of clinical training as it does about PTSD. But it does reflect a widespread appreciation that veterans may have a number of reasons for wanting to be labeled with PTSD. They may want to participate in a study for which they'll receive compensation money. They may find that PTSD provides what clinicians call "secondary gain," offering some social or psychological or financial benefit that comes along with the diagnosis, and which may be satisfactory enough to make it desirable despite the additional baggage of its stigma. Veterans might want to identify with having been in combat (whether or not they actually have), given that combat is one experience that is held to be sound proof of one's heroism. There are other kinds of gain as well. One psychologist I interviewed described a veteran he had treated several years back; he told of how, every time the veteran began to describe his PTSD symptoms, the wife would take his hand between hers and stroke it with a worried expression on her face. Her loving concern, too, could be understood as providing secondary gain.

Beyond secondary gain, there are veterans who may experience a generalized psychological distress that manifests in the form of PTSD, simply because – after all those military briefings and cautionary tales and articles in the news – PTSD is the example of distress they have come to know best. They may have learned to pay attention to PTSD-like symptoms more than to symptoms reflecting depression or anxiety or even the ordinary, non-pathological misery of everyday life.[35] There are, in short, many reasons why American veterans may express PTSD the way they do. Still, even with all the caveats, the domestic and cross-cultural evidence

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[35] This is consistent with the understanding of somatic modes of attention (L. Kirmayer & Young, 1998).

does suggest that PTSD is best understood as a universal phenomenon with important local and individual variations. Individuals may come to PTSD for a wide variety of voluntary, involuntary, conscious, and unconscious reasons, but the illness itself reflects something common in the human experience.

To those who rightfully critique the illness category of PTSD as an imperfect entity – identifying problems with the diagnostic criteria, limitations of the disorder for describing the range of human experience, and so forth – it seems useful to propose a series of criteria by which it should be judged. To my mind, the essential question is this: does the construct of PTSD provide a way of describing a particular experience of human suffering that acknowledges, helps to identify, and provides a means of offering support and healing for that experience? I believe that most of those who have debated the nature of PTSD would agree that what matters are the following:

1) That those whose lives have been disrupted by trauma have access to a name (or names) for their experience that provides respectful acknowledgement of their suffering;

2) That there be a name and definition for trauma-related suffering that helps to distinguish between those who are in the process of healing and those who have gotten caught up somewhere along the way, making it possible to identify and provide help to those who are not healing in the way they would like to be;

3) That this name and definition be flexible enough to recognize that such suffering may look somewhat different in different social and cultural settings, because humans are vastly heterogeneous;

4) And that this name and definition be constructed in such a way that they leave room for identifying effective means by which to aid in healing. (And since clinicians sometimes

are made uncomfortable by squishy social science words like “healing”, let me also say it this way: that the name and definition be constructed in such a way that people who are suffering after trauma can be helped to suffer *less*.) This is, after all, the goal of naming illness in human life: to use that name to find ways to help minimize suffering.

When these goals are kept in mind, it strikes me that PTSD can be considered as useful an illness construct as any other, although it remains very much a work in progress, both in terms of social meanings and of scientific understanding. It is inevitable that PTSD will continue to be a politicized and socially contested entity, for the simple reason that the illness is inevitably linked with issues of suffering and culpability. It raises questions like, who is suffering? Who is responsible for that suffering? What are the appropriate responses to such suffering? Whose responsibility is it to make sure those responses are meted out as intended? Because attitudes toward suffering, responsibility, and culpability are foundational elements of culture, these concerns, too, are likely to be understood differently across cultural worlds.[36]

Wounded Warriors

None of this, of course, addresses the question of how the United States will deal with the distress of veterans returning from the wars in Iraq and Afghanistan. For the time being, the wars themselves have slipped from the forefront of public attention. When the satirist and comedian Stephen Colbert recently began taping his fake-news show in Iraq – the first time an American comedy program has been taped entirely in a combat zone – the primary response from deployed service members hovered along the lines of, ‘it’s nice to know everybody hasn’t

[36] (Kleinman, Das, & Lock, 1997a; Sundar, 2004)

forgotten us.'[37] President Barack Obama has pledged to withdraw the majority of American troops from Iraq over the coming year, but as the war in Iraq shows signs of winding down, increasing numbers of Americans are being deployed to Afghanistan to fight the insurgency there. It appears as though one war will simply segue into another.

Meanwhile, the toll of combat-related psychological distress continues to grow among veterans of these wars, although its visibility comes and goes with the news cycles. There has been less reporting on veterans' PTSD in recent months, just as there has been less reporting on the wars. The issue breaks through occasionally, as when Kentucky's Fort Campbell recently closed down all operations for three days to conduct a massive anti-suicide campaign among its much-deployed soldiers, 11 of whom had committed suicide in the preceding five months.[38] But no matter how frequent the news reports, the burden of these wars has not, thus far, been a shared one. They have been paid for by the American people as a whole, but they have been largely fought and sacrificed for by military families and communities, leaving too many of the rest of us able to ignore the daily cumulative consequences. The burden has been disproportionately borne by those who are young, poor, and undereducated, and has been measured out all too literally in losses of flesh and blood.

For now, the image of the service member who is left physically or psychologically injured by war remains a powerful one in the American psyche. Despite the presence of considerable stigma around PTSD, I think most Americans, in the abstract at least, are sympathetic towards service members and their post-war needs. Their "Support the Troops" attitude has held strong thus far. The question remains, however, whether Americans will

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[37] (Lawrence, 2009)
[38] (Press, 2009)

continue in their commitment to the troops ten years from now, when the wars will (I can only hope) be long finished, and when the healthcare, educational and other resources required by veterans may begin to seem – as they have after prior wars – like too much of a burden. Veterans with PTSD can, at times, present as unsympathetic figures. As the perceived glory of their service fades into the past, it can become too easy to focus on the anger and aggression associated with their illness. Veterans with PTSD, particularly when they are angry, are not always an easy group for which to summon compassion and the desire to help.

It is impossible to know now how many veterans of Iraq and Afghanistan will end up with a PTSD diagnosis. As of August 2008, more than 75,000 OEF/OIF veterans had already been diagnosed with PTSD, and the number is likely to rise into the hundreds of thousands.[39] Although our understanding of the relationship between PTSD and suicide remains limited, many have watched the U.S. Army's steadily increasing suicide rates over the past several years and read this as evidence of untreated or undiagnosed PTSD.[40] In addition to the toll of human suffering, the burden upon national healthcare and benefits resources will be immense. In the five years between 1999 and 2004, the number of veterans awarded disability compensation for PTSD increased by 79.5% (compared with an average 12.2% increase across all disabilities).[41] It is clear that PTSD and related health concerns will present a significant challenge over the coming decades for veterans, their families, the U.S. military and the VA.

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[39] (*Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans.*, 2008)
[40] One recent nation-wide study of suicide among veterans found that a comorbid diagnosis of PTSD and depression actually predicted lower rates of suicide than did a diagnosis depression alone; however, this study considered a cohort of veterans during the years 1999-2004, prior to the military's suicide increase (Zivin, et al., 2007). It is unclear whether active PTSD may be in some part responsible for the increasing suicide rate among more recent veterans.
[41] (Frueh, et al., 2007)

It is also clear that nearly all veterans of Iraq and Afghanistan will experience some amount of "readjustment" after long deployments away from their families. I have come to agree with the military's assessment that it is essential to differentiate between readjustment and PTSD, if only because the majority of those who go through some period of re-acclimating to life at home manage to accomplish the task, and should not be unnecessarily weighed down by the stigma or pathology of a diagnosis. Readjustment is a condition of normal re-adaptation to a previously familiar environment after an extended exposure to intense stress in a different environment. PTSD, by contrast, is a condition in which trauma impairs the ability to readjust. This is an essential difference, and there is considerable danger in convincing veterans that their experiences with suffering inevitably mean disability rather than an opportunity for resilience and even personal growth.

Of all the veterans interviewed in this study, not one ever said to me, 'I wish I'd never heard of Iraq or Afghanistan.' All of them valued their time in the combat zone, if only because of what it taught them about life and purpose and love and loss, about what extraordinary things are possible when one is stretched to the very limit. It will be important to remember this over the long-run, and to maintain the expectation that – with appropriate support and opportunities – most veterans will flourish in their time after service.

There has been some discussion recently of whether and to what degree PTSD is being overdiagnosed among recent veterans.[42] This is and will remain a tricky political issue, precisely because of the access to treatment and compensation made available to veterans given a PTSD diagnosis. Those brave enough to take on this issue in the public forum will need to strive for a

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[42] (Dobbs, 2009; Frueh, et al., 2007)

balance of sensitivity and specificity – working to ensure that the criteria for diagnosing PTSD are sufficiently sensitive to catch all those who are in need of additional treatment and support, while not over-diagnosing the illness among those who are functioning well. This is an issue of cost-effectiveness (which it is safe to predict will be one focus of the surrounding political debate), but more importantly, it is an issue of avoiding either neglect or learned helplessness. Combat PTSD has the potential to become an identity as well as an illness, and this may not always be to the good.

Recommendations

Despite the daunting scale of these challenges – and at the risk of sounding like an optimist – I am made greatly hopeful by two things. First, resilience, that adaptive ability to continue functioning after stress or trauma, is far more common than PTSD. Only a minority of those exposed to trauma develop PTSD, and so it is reasonable to expect that most OEF/OIF service members will return home and do very well. To date, it remains unclear to what degree resilience is a *trait*, an inborn or acquired characteristic, and to what degree it is a *process*, a series of cognitive and/or physiological adaptations. However, there is a lively research movement afoot to explore just exactly how resilience works, and it may be that the study of resilience will offer new insights into ways that we might learn to teach resilient coping strategies, behaviors, or attitudes.[43]

Second, the cumulative evidence suggests that PTSD is responsive to a number of the newer treatments, such as certain medications and the exposure-based cognitive behavioral

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[43] (e.g. Bonanno, 2004; D. C. Johnson, et al., 2008; Sammons & Batten, 2008; Tusaie & Dyer, 2004)

therapies, although the wide-spread effectiveness of these treatments for combat veterans has yet to be tested. Witnessing the recovery of individuals like Chris and Derek has been extraordinarily moving for me, and I can only hope that the immeasurable effort both clinicians and veterans are putting into these treatments will pay off. Given the political and professional debates involved in such a task, it will be a tricky thing to shift the model for PTSD illness from one of chronic disability to one of recovery. But if this should come to pass in such a way that most PTSD-diagnosed veterans themselves feel truly better off – with their symptoms in remission, perhaps, if not full recovery – the benefits would be entirely worth the battle.

At the same time, clinical treatments, while an essential part of the picture, should not be seen as the only venue for helping to minimize the impact of PTSD on veterans and service members in the coming decades. There are a variety of ways in which actions taken at all levels – from steps taken by the individual right on up through national policy – have the potential to make an important difference in the well-being of those returning from Iraq and Afghanistan. Here is a short list of approaches that should be prioritized:

A. Recommendations for preventing combat PTSD*:*

1. *Avoid armed conflict.* This is the most obvious and important way to prevent combat PTSD. My reading of history suggests that most violent conflicts can be prevented by the serious application of non-violent solutions. Armed conflict should always be a last resort.

2. *Encourage the creation of informal spaces in which service members can talk openly about their deployment experiences.* When interviewed for this study, several psychologists who had served on the ground in Iraq described taking advantage of opportunities to talk informally with service members, usually in a small group setting, about their experiences

with deployment. Although formal programs for discussing crisis events – such as debriefing episodes after the wounding or death of unit members – have received mixed reviews in the research literature[44], clinicians anecdotally described the positive effects of talking over day-to-day and crisis-level stressors during smoking breaks, while playing video games, and during other casual group activities. Discussing stressors and crises in these settings can provide service members an opportunity to process their experiences and draw on the social support resources of the group without pathologizing their reactions or exposing them to stigma. Further research should be done to explore the possible role of such settings and conversations in processing combat trauma.

3. *Continue to focus on anti-stigma efforts in the military and veterans' communities*. Efforts already ongoing can be strengthened by a more explicit focus on supporting mission readiness through positive self-care. Many of the veterans in the PDS study described deciding to seek care out of a sense of obligation to family members; some active duty service members also acknowledged that they were unable to make a full contribution to their unit's well-being when psychological distress began interfering with their ability to function. By encouraging an ideal of strength and masculinity that emphasizes prompt care-seeking as a way of living up to one's obligations to unit and family, anti-stigma efforts will be better equipped to counteract the U.S. military's cultural focus on group well-being through self-denial.

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[44] (Cuijpers, Van Straten, & Smit, 2005; Rose, Bisson, Churchill, & Wessely, 2009)

4. *Provide support for resilience research.* Although resilience in the wake of traumatic events has until recently remained underexplored,[45] there is evidence to suggest that educational, pharmacologic, and psychosocial interventions may all have an important role to play in increasing resilience among service members deployed to combat zones.[46] Further research in these areas has the potential to a go a long way toward developing programs aimed at minimizing the impact of trauma exposure on service members' physical and mental health over the life course.

5. *Provide support for research on military families.* Families face their own difficulties with long deployments, and much can be done to minimize their struggles by providing adequate social and institutional support. Clinicians and researchers have made great strides in this area over the past several years – witness the Battlemind program described in Chapter Five – but there is still a need for evidence-based programs aimed at supporting families during long deployments. Given that family problems arising during deployment may erupt into stressful situations that inhibit readjustment for service members after deployment, such programs have the potential to support post-combat resilience as well as family well-being. These programs should also strive to provide education on what readjustment may mean for family relations, and how best to help service members struggling in the readjustment period.

B. Recommendations for minimizing the severity of combat PTSD:

6. *Improve veterans' and service members' access to appropriate mental health care.* The San Antonio VA has one of the best veterans' hospitals in the country, with health

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[45] (Bonanno, 2004; Tusaie & Dyer, 2004)
[46] (Bonanno, 2004; Davidson, et al., 2005; Williams, Alexander, Bolsover, & Bakke, 2008)

outcomes rated in the top 10% across the U.S. Not all veterans, however, have access to such care. Many American veterans, particularly those who live in rural or underserved areas, may have to travel long distances to access the resources available, making it impossible or impractical to attend the multiple appointments necessary for establishing and maintaining adequate treatment.[47] Likewise, service members' access to mental health care while on active or reserve duty appears to be inconsistent, varying by service branch, service location, and local leadership goals and priorities. Achieving consistent access to quality care for all veterans and service members must remain a top priority.

7. *Continue to support research on therapeutic and pharmacological treatments for PTSD.* Although there has been tremendous growth in this area over the past two decades, the coming years will present an unprecedented opportunity to evaluate how effective current treatments are in treating PTSD, as growing numbers of veterans and service members find their way into care. Despite the challenges of caring for all of those flooding into mental health clinics, clinicians and researchers must maintain their focus on evaluating the treatments on offer in order to continue the process of identifying and refining best practices. This research focus should extend to the continued investigation of basic mechanisms in the onset and maintenance of PTSD, in hopes that accumulating knowledge will illuminate new methods for preventing and treating the disorder.

8. *Invite families to be involved in treatment.* The findings of this study suggest that families who have a solid (clinical) understanding of PTSD's symptoms and causes may be less likely to exhibit stigma toward the veteran and more likely to develop positive coping

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[47] (Elhai, Baugher, Quevillon, Sauvegeot, & Frueh, 2004)

strategies that minimize the impact of PTSD.[48] A number of clinicians have also begun to argue for involving spouses and other family members more directly in PTSD treatment.[49] Movement in this area will require additional research on family attitudes towards PTSD, relatively scarce until recently, and will provide opportunities for formulating and evaluating partner-focused treatment as well health promotion and literacy programs.

9. Involve veterans of all ages in outreach efforts. Veterans in the PDS study were often reliant on other veterans – whether close friends, family members, or former superiors – in making sense of their struggles with PTSD and in selecting options for coping and care-seeking. Both the military and the VA have made efforts to take advantage of these naturally occurring networks to encourage appropriate care-seeking and other self-care behaviors; the military by educating service members on how to recognize PTSD in others, and the VA by including video testimony from veterans who have completed treatment in their orientation seminars for newly PTSD-diagnosed veterans. These are excellent beginnings, but more can be done to involve local veterans in outreach and educational efforts, a strategy that has the added benefit of empowering veterans to have a voice within local care networks, thus fostering positive relations between veterans and the institutions intended to serve them.

10. Continue to invest in dual diagnosis treatment and research for veterans with comorbid PTSD and substance use concerns. Mental health care providers have historically insisted that PTSD-diagnosed patients attain sobriety before beginning PTSD treatment. The VA

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[48] The implication here is that – similar to Jenkins' research on expressed hostility among families of those with schizophrenia – family attitudes may increase the struggling member's psychological distress, thus in turn increasing the amount of probable impact on role function and family life (Jenkins, 1991).

[49] (Erbes, Polusny, MacDermind, & Compton, 2008; Monson, Fredman, & Adair, 2008; Rotunda, O'Farrell, Murphy, & Babey, 2008)

has recently acknowledged that this strategy may actually be counter-productive, as veterans often engage in alcohol and drug use in an attempt to manage their PTSD symptoms. A number of efforts are being made to address this problem through research aimed at addressing PTSD and substance abuse programs simultaneously,[50] and by hiring providers at VAs across the nation to serve as specialized Dual Diagnosis Coordinators for veterans with PTSD and substance use needs. However, there is evidence to suggest that individuals with simultaneous PTSD and substance disorders may be less responsive to many of the treatments effective for those with PTSD alone, and that this group may have special needs not fully accounted for by current best practices. [51]

11. *Remain committed to the goals of patient-centered care.* The organizing tenets of a patient-centered care model are widely considered to be an essential part of the VA's remarkable transformation over the past decade, a shift that has taken the nation's largest health system from providing mediocre to providing very good care. Under a patient-centered care model, the focus is placed on centering control in the hands of the individual patient (rather than the provider), and on extending care beyond the clinic into the patient's home and community, striving to provide a seamless network of care that is responsive to all of a patient's needs (e.g. both mental health and substance abuse treatment).[52] One of the findings of the current study has been that Latino and Non-Latino veterans in San Antonio do not necessarily vary greatly in their experiences of PTSD; to assume otherwise may well interfere with a provider's ability to be responsive to the needs of the individual patient. As more and more

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[50] (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008; Rotunda, et al., 2008)
[51] (Corrigan & Cole, 2008)
[52] (Perlin, Kolodner, & Roswell, 2004)

research explores the needs of particular groups with PTSD (e.g. Latinos, women, sexual assault survivors, etc.), it will be essential to incorporate the knowledge gained into treatment practice without ever losing sight of the fact that every person's experience of PTSD is unique.

C. Recommendations for decreasing the impact of combat PTSD on families:

12. *Include family-level outcomes in PTSD treatment research*. One concern that arises in taking an anthropological view on the PTSD literature is how frequently studies focus solely on the well-being of the individual with PTSD. This is a predictable outcome of the biomedical perspective, which tends to view disease as a product of dysfunction in the individual body. However, an overly single-minded focus on the individual can deflect attention from the very important ways in which PTSD may be both shaped by and a detriment to social relations. One simple way to increase attentiveness to these concerns is to encourage researchers to regularly include measures of family members' physical, social, and mental well-being in PTSD research.

13. *Prioritize the safety of all family members.* Although family violence appears to be a concern for only a minority of PTSD-diagnosed veterans, this is a topic that calls out for more investigation than it has received until now. The findings of the current study suggest that family violence committed by PTSD-diagnosed veterans may fall into patterns that do not entirely fit the classic batterer paradigm, and that a better understanding of these patterns may be essential to helping veterans and their spouses take steps to prevent violence and ensure the safety of all family members.

D. Recommendations for supporting resilience at the national and community levels:

14. *Consider instituting a national service requirement for all American youth.* Many countries require all citizens to engage in a year or more of national service as young adults. This requirement may be fulfilled by military service or a variety of non-military alternatives, including teaching in rural areas, engaging in civic development projects, etc. I have come to believe that a national service requirement among American youth that includes an option of military service would help to re-engage certain sectors of American society – namely, the upper middle and upper classes – with the realities of military service, thus keeping Americans more fully cognizant of the risks involved with engaging in unnecessary armed conflict. I cannot count how many people have said to me over the past several years that they would have protested the invasion of Iraq if their child had been in the military. The separation of military and civilian societies in the decades since the end of the draft has made it far too easy for the most powerful sectors of American society to remain also those most distant from the costs and consequences of military action. Reuniting military and civilian communities would go a long way towards beginning to address this social and structural inequality.

15. *Continue to focus on supporting the troops.* Americans on the whole have continued to express support for American service members serving overseas, despite considerable protest as to the handling of the wars in Iraq and Afghanistan. This attitude plays an important role in supporting the reintegration of post-war veterans back into civilian society, and also in keeping the public eye on those who would cut corners in providing exceptional resources and healthcare to veterans and service members. Public opinion is a vital force in leveraging change when change is necessary.

16. Expect that all combat veterans and other trauma survivors will remain resilient after a period of healing. Convey that expectation of recovery. As important as it is to ensure

that all service members and veterans have adequate access to quality mental health care services, it is equally important that Americans not come to believe that PTSD is an inevitable outcome of combat (or trauma more generally). The majority of those exposed to trauma, even combat, will never develop PTSD. They may struggle for a while, they may need to process their experiences internally and in conversation with others, but they will never be made unable to function by their experiences. Daniel Moerman has written about the extraordinary power of what he calls the "meaning effect" – otherwise known as the "placebo effect" – that poorly-understood process by which human beings get sick or well according to their expectations of what will happen to them.[53] Science has proven time and time again that it is possible to make people well with a placebo, just as it is also possible to make them sick with what is called a nocebo.[54] This expectation of recovery and resilience must be made structural as well as cultural; in other words, the expectation of recovery must be built into military and VA systems of benefits and compensation as well as into cultural and professional understandings of resilience and PTSD. This will require a considerable overhaul of the current system, and must take into account the actual progress that OEF/OIF veterans with PTSD are able to make in re-establishing their lives post-deployment and post-treatment. There are no easy answers for how to do this, but the current system must be stripped of provisions that encourage veterans to remain chronically disabled when they need not be, while leaving those who are truly disabled with the support they require.

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[53] (Moerman, 2002)
[54] (Hahn, 1998)

It should be taken as the basis for tremendous hope that nearly all of these recommendations are already in motion.

Final Thoughts

There is no way to undo PTSD, just as there is no way to undo trauma. There is no way to go back and give Derek back his leg or to bring Chris' lost friends back to life. These men will be forever changed by their experiences, and so – perhaps – it should be, for them and the tens of thousands of veterans like them. But if it should also prove possible to minimize the power of trauma to disrupt the course their lives and the lives of their wives and children, this would truly be a thing of wonder.

I have lately found myself drawn to the art of earlier wars – including 1946's "The Best Years of Our Lives," a movie which has perhaps the most well-rounded portrayal of combat veterans struggling with readjustment and PTSD ever brought to film. It is widely known that Erich Maria Remarque wrote <u>All Quiet on the Western Front</u> in the wake of his own experiences in WWI, but less well remembered that he published a sequel to that book in 1930, entitled <u>The Road Back</u>. The challenges depicted in it, of soldiers returning home to find that life is not as they left it, would seem familiar to readers. They tell of dislocation, nightmares, suicide, estranged relationships, and the uneasy bonds between veterans. Reflecting on the unsettled strife of post-war soldiers, Remarque wrote:

> We thought to build us houses, we desired gardens with terraces, for we wanted to look out upon the sea and to feel the wind, but we did not think that a house needs foundations. We are like those abandoned fields full of shell holes in France, no less peaceful than the other ploughed lands about them, but in them are lying still the

> buried explosives, and until these shall have been dug out and cleared away, to plough will be a danger….[55]

There is, in his words, the wistful hope for a life that will have in it all the good and necessary things – for Remarque, a house, a garden, a view to the sea. Perhaps for the veterans in the PDS study, the list would include a good marriage and family life, satisfying work, and a sense of oneself as a man to be proud of. But Remarque captures, too, that sense of what barriers the war has created for the fulfillment of dreams. Fields cannot be fertile if riddled with shell.

For the men in these pages, the struggle to manage PTSD is the struggle to build a life worth living. To do so, they must navigate the grinds of money and work and institutional resources. They must weave and maintain the many-threaded fabric of close relationships. And they must find acceptable ways to understand themselves as men with PTSD amidst the many possible versions of PTSD they find in the worlds around them. They may be distracted along the way by grief, regret, fury at their own deep knowledge of tragedy, and a transformed way of experiencing the world around them. But there can be no higher stakes, and so their struggle continues – until they slip and fall under the weight of the burden they carry, fulfill the quiet triumph of finding some manageable peace, or come to a place where they can, at the least, put the burden down to rest for a while.

There are no happy endings, if only because, in real life, there are few endings. Life continues in process, and even death does not bring an end to the resonance one may have had in life. But a house must have firm foundation. And a field, once the shells are cleared away, may again and forever be fertile.

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[55] (Remarque, 1930: pg 292)

Theoretical Underpinnings

Appendix A

A Brief History of the Field: Psychiatric Anthropology

It is helpful to frame the analysis conducted in this dissertation within the larger field of psychiatric anthropology[1] and its development over the past century.

At the time anthropology emerged as a discipline in the mid-1900s, its founding scholars were engaged in defining issues that have remained central to the field - including evolution, culture, and society - and did so within the overriding aegis of an imperialist age.[2] The colonialist venture brought Western scholars in contact (actual or intellectual) with "primitive cultures," peoples whose ways of life and beliefs about the world were utterly different from their own. Early anthropological efforts, therefore, emphasized the description and documentation of these strange ways and beliefs, and attempted to bring order to the chasms

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[1] I use the term "psychiatric anthropology" here because it is far more concise than "the medical anthropology of mental health and illness," but I do so with the caveat that a medical anthropology aspiring to understand mental disorder should be wary of allying itself too whole-heartedly with psychiatry. I believe the greatest strengths in the relationship between psychiatry and anthropology are to be found in their "antagonism and reciprocity," and that a medical anthropological view to mental health and illness would be weakened by positioning itself solely in relation to psychiatry, as naming itself "psychiatric anthropology" would imply. Moreover, some of the most interesting developments in this area are occurring within the multiplying number of clinical disciplines affiliated with professional mental health care, such as clinical psychology, social work, marriage and family therapy, etc. To focus too closely on psychiatry is to leave out other disciplinary perspectives that are, in their own dialogues and practices, having an ever greater impact on the conceptualization and treatment of mental health and illness in American life.

[2] (Bohannan & Glazer, 1988)

between "primitive" and "civilized" life using a cultural evolutionary framework. Many of the earliest efforts in medical anthropology must be seen in this light, as efforts to document cultural variation in concepts of health and disease, such as Rivers' 1915-1916 lectures on "Medicine, Magic, and Religion," which described concepts of disease in Melanesia.[3] Casey and Edgerton have argued that the earliest *theoretical* orientation in psychological anthropology was that of Freudian psychoanalysis,[4] and certainly Freud's own Totem and Taboo, which utilized psychoanalytic insights as a framework for interpreting anthropological data on incest taboos and totem-based social organization, was an important early work.[5]

Anthropology moved away from a cultural evolutionary viewpoint under the guidance of Franz Boas, who rejected Social Darwinist notions linking race and primitive culture, replacing these with an ideal of cultural relativism, in which all cultures were to be seen as "equal and comparable".[6] Boas' reformulation set up a new paradigm for comparative ethnology, and several of Boas' students began grappling with the question of how to understand differences, not only in cultural beliefs and practices, but in temperament, behavior, and personality. The "Culture and Personality" movement that developed, which included important works by Ruth Benedict,[7] Ralph Linton,[8] and Abram Kardiner,[9] investigated how cultural norms for ideal behavior communicated through child-rearing practices and other social institutions might result in broad differences in "national character".[10] The emphasis on child-rearing practices

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[3] (Rivers, 1924)
[4] (2005)
[5] (1913)
[6] (Bohannan & Glazer, 1988)
[7] (1960[1934], 1974[1946])
[8] (1945)
[9] (1945)
[10] (Bateson, 1972[1942])

betrays the continuing influence of Freud's developmental framework, but these works also drew on cultural anthropology-informed analysis, and ethnographic methods of fieldwork and participant-observation. In the years after World War II, however, Culture and Personality fell out of favor, critiqued as overly political and lacking in objectivity.[11]

Following the decline of Culture and Personality, works in psychological and medical anthropologies continued to explore cultural variation in notions of health and illness,[12] with a number of anthropologists investigating what came to be called "culture-bound syndromes," named phenomena of clustered symptoms or behaviors occurring in a particular place or region, such as *susto* or *nervios* in Latin America[13] and *amok* or *latah* in Southeast Asia.[14] These works were influenced by the growing sophistication and specialization of anthropology as a whole, in several ways. First of all, ethnographers had moved away from attempting to describe entire cultural systems of health and healing (such as Rivers had done) and were increasingly focused on specific foci within these systems. Second, scholars in this era began to explore the relation between experiences of health and illness and the task of living within cultural norms and larger structures of social power and change. As a case in point, Arthur Rubel observed that a Mexican-American lay curer living amongst Anglo-Americans in South Texas took pride in healing a case of *susto* or *empacho*, not only because the patient's suffering had been eased, but because "…each success of a traditional healing procedure is a vindication of traditional modes which are beset by pressures to change".[15] Finally, the literature on culture-bound syndromes

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[11] (Casey & Edgerton, 2005)
[12] (e.g. Edgerton, 1966; Metzger & Williams, 1963)
[13] (e.g. C. O'Nell, 1975; A. J. Rubel, 1960)
[14] (R. C. Simons & Hughes, 1985)
[15] (A. J. Rubel, 1960: 814)

represented some of the earliest efforts to bring together anthropological and epidemiological methodologies in exploring the distribution of behaviors, beliefs, and illness, reflecting a growing use of multi-methodological frameworks in other areas of anthropology.[16]

In the 1960s and 1970s, however, the radical critiques of feminism and Foucault were launched, with lasting implications for all of anthropology. Cultural constructions of knowledge, power, gender, and ethnicity were called into question, and psychiatry itself came under fire within anthropology and the humanities, critiqued as a mechanism for labeling and stigmatizing social deviance.[17] The anti-psychiatry movement within anthropology was short-lived (although echoes of it can be seen today in some critical medical anthropology and other works critiquing the hegemony of Western psychiatry)[18], but the newly identified necessity of distinguishing between cultural norms and structures of socioeconomic and political inequality had great resonance for medical anthropology. For example, the literature on culture-bound syndromes, although it continued to flourish throughout this period and remains relevant today,[19] came under fire for assuming the legitimacy of bounded, homogenous cultures and for contrasting the "culture-bound" syndrome with biomedical categories of illness which were thus presumably "acultural".[20] In 1981, Nichter proposed an alternative construct, "idioms of distress," which maintained a focus on clusters of symptoms with locally-defined relevance, but moved beyond the culture-bound syndromes model by explicitly interrogating how individuals experience

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[16] (Bohannan & Glazer, 1988; Casey & Edgerton, 2005). Casey and Edgerton (2005) include a helpful discussion of this era in anthropology, particularly noting the importance of methodological advances in work by John and Beatrice Whiting, Irwin Child, Robert Edgerton, Melford Spiro, and Robert LeVine.
[17] (Foucault, 1965; Laing, 1967; Szasz, 1974[1960])
[18] (Gaines, 1992)
[19] (e.g. Mezzich, et al., 1999)
[20] (Hahn, 1985; R. C. Simons & Hughes, 1985)

distress within the constraints of local structures of gender and power, and how they respond to such distress through particular modes of expression and care-seeking. Social relations that had been implicit in earlier work – e.g. Rubel's observation that the Mexican-American lay curer took pride in maintaining the viability of his ethnomedical system despite the pressure of conflicting norms in the local Anglo-American community – were increasingly made the explicit focus of theory and research.

The year 1981 offers a good moment to stop and consider major changes that had been ongoing in psychiatry during this time. Throughout the first part of the 20th century, psychiatry in the U.S. and Europe was overwhelmingly influenced by Freudian psychodynamics, which presumed the importance of developmental influences, social relationships, and internal conflicts between emotion, motivation, thought, and action.[21] Psychoanalysis provided the primary therapeutic model for treating mental illness, and its emphasis on metaphor, symbol, and child-rearing practices - as well as its models for consciousness and neurosis - were potent influences throughout the social sciences and humanities, with anthropology being no exception.[22]

However, with the identification in the 1950s and 1960s of pharmacological medications that dealt effectively with the symptoms of previously intractable mental illnesses like schizophrenia, psychodynamic psychiatry began to face competition from a more biologically-driven perspective, which focused on genetic vulnerability and a view of neural and endocrine

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[21] (Luhrmann, 2000; P. R. McHugh & Slavney, 1998; Millon, 2004)

[22] For example, Levi-Strauss' (1963) analysis of shamanic healing rests on the psychoanalytic notion of abreaction, in which the patient relives the event or situation that led to psychoemotional disturbance.

pathways as subject to disease and disorder.[23] Over time, pressures internal and external to psychiatry resulted in a dramatic shift towards the biomedical view in teaching, research, and treatment.[24] Thus, the psychodynamic emphasis on life history and social environment as key factors shaping mental health and illness was largely replaced by a biomedical emphasis on psychopathology as a disease of the brain.

This shift was accompanied by a move toward the standardization of psychiatric diagnosis and treatment, most importantly in the 1980 revision of the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Volume (DSM-III)*, which established the first comprehensive algorithmic nosology for diagnosing mental illness.[25] Goodwin and Guze have (rather gleefully) noted the extent of the change this revision created in psychiatry:

> Possibly fatigued by unsupported theory, psychiatrists may have found some satisfaction in agreeing on what to call things….Also, with the discovery of relatively specific drug therapies, diagnosis had become *practical*…. With the emphasis on diagnosis, use of words like *data*, *reliability*, and *operational* increased. Journals brimmed over with graphs and tables….People actually stood up at meetings and asked: 'Where is the evidence?' (italics original)[26]

Some gauge of the consequences this change in psychiatry had for psychiatric anthropology can be taken by noting that, with the possible exception of schizophrenia, anthropologists prior to the DSM-III revision rarely wrote about specific mental diagnoses. Sue Estroff's classic ethnography, Making It Crazy, only occasionally makes mention of the diagnoses of her study participants.[27] Diagnosis is never even discussed in Goffman's Asylums.[28] Nancy

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[23] (Luhrmann, 2000)
[24] (Luhrmann, 2000)
[25] (Young, 1995)
[26] (1996: vii-viii)
[27] (1981)
[28] (1961)

Scheper-Hughes' ethnography of schizophrenia in rural Ireland was a significant exception to this rule, but explored the diagnosis in the context of proposing a culture-based etiology grounded in psychodynamic notions of child-rearing and repressed sexuality.[29]

In noting how these shifts in psychiatry were reflected in psychiatric anthropology, it seems relevant that the driving figure in the field over the past thirty years – Arthur Kleinman – trained and practiced in clinical psychiatry before becoming an anthropologist. Certainly, the growth of transcultural psychiatry,[30] which makes heavy use of both epidemiologic and ethnographic methods and analysis to address questions of mental illness causation, course, and severity,[31] has been marked by the same demand for reliable, valid, and operationalizable data described by Goodwin and Guze. Nonetheless, psychiatric anthropology has also remained subject to many of the ongoing crises and shifts within anthropology. Post-modernist influences led psychiatric anthropologists to query, not only the construction of psychiatry but that of heterogeneous *ethnopsychiatries*, especially those in the developing world.[32] Critical medical anthropology, responding to a resurgence of Marxist and material approaches in anthropology, has put forward blasting critiques of biomedicine, prompting a reinvigorated investigation of the political economic implications of diagnosis, treatment, and drug marketing for shaping understandings of mental distress.[33] Efforts to promulgate a sophisticated biocultural view of

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[29] (Scheper-Hughes, 2001; 2001[1977])
[30] Also called cross-cultural psychiatry, or simply cultural psychiatry.
[31] (Canino, Lewis-Fernandez, & Bravo, 1997; L. J. Kirmayer, 2006; Littlewood, 1990)
[32] (Gaines, 1992)
[33] (Gaines, 1992; B. J. Good, 1994; Metzl & Angel, 2004)

well-being have resulted in important work linking physiological stress and depression to cultural norms and socioeconomic constraints.[34]

Thus it is clear that the tensions and orientations of psychiatric anthropology have emerged in relationship with anthropology as a whole, including struggles around what constitutes meaningful evidence, what strategies and foci of analysis are most valid, and what priorities should be reflected in the research undertaken. Perhaps the most essential tension in the field at the current time, however, are based around the question of anthropological praxis, and this is an important question to discuss in framing the current work.

Merging Clinical/Critical Perspectives

Although researches in the realm of psychiatric anthropology remain heterogeneously informed by a variety of questions and empirical traditions, the issue of how to approach psychiatry remains a key point of debate in the field. For psychiatric anthropologists, psychiatry alternately represents a cultural construction overzealously claiming authoritative knowledge,[35] a vector of Western values in a globalizing world, [36] or a medical specialty with the capacity to reduce suffering and distress[37] – disparate viewpoints that beg the question of what role anthropologists should take in aiding, abetting, or undoing psychiatry. For some scholars, tackling psychiatry means taking a critical approach, exploring its production and dissemination as a system of cultural knowledge informed by the sociopolitical, material, and ideological

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[34] (Dressler, 1991; Dressler, Baliero, & Dos Santos, 1997)
[35] (Young, 1982)
[36] (L. J. Kirmayer, 2006)
[37] (R. Desjarlais, Eisenberg, Good, & Kleinman, 1996)

circumstances of its inception.[38] Allan Young's The Harmony of Illusions represents this approach, deconstructing the intellectual history of traumatic memory, the process of political and professional advocacy by which post-traumatic stress disorder was accepted as a DSM-III diagnosis, and the narratives, technologies, and practices by which psychiatrists in the 1980s identified and enacted PTSD in the clinical world.[39] Gaines' edited volume Ethnopsychiatry takes a similar tack, proposing a cultural constructivist approach by which to critique "Western beliefs, practices, and institutions," including "professional ethnomedicines", "classificatory systems", and "education, organization, and practice".[40] The essential point, argued Gaines, is to recognize medical knowledge as a cultural entity, varying in its ideologies and practices across the Western and developing worlds.

The portrayal of biomedical knowledge, including psychiatry, as "scientific" and "rational' is problematic for a variety of reasons, not least because of its capacity to silence other ways of knowing, other classifications, diagnoses, treatments, methods of identifying and healing distress.[41] Psychiatry, in its capacity as a authoritative body of knowledge, also has the ability to assign stigmatizing labels to individuals whose behavior is considered socially deviant (as in the case of homosexuality, which remained a DSM diagnosis until 1973),[42] as well as to legitimate abuses of power (as in the case of *drapetomania*, the 19th-century "disorder" of slaves who continually tried to flee their bondage).[43] Psychiatry has been accused of bowing to

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[38] (B. J. Good, 1994; Lock, 1993; Scheper-Hughes & Lock, 1987)
[39] (B. J. Good, 1994; Lock, 1993; Scheper-Hughes & Lock, 1987)
[40] (1992: 18)
[41] (Young, 1995)
[42] (Lamberg, 1998)
[43] (Bynum, 2000)

pharmaceutical interests,[44] as well as overstepping its bounds in the response to war and disaster in the developing world,[45] and of locating suffering caused by macro-level sociopolitical forces within the mind and body of individuals, thus evading the problem of assigning responsibility in the search for social justice.[46]

Participants in a psychiatric anthropology, then, can rightfully claim that psychiatry is culturally-, historically-, and materially-situated product that encompasses great variety in its ideologies and practices, and that is subject to the same uses and abuses as any other power structure. Nonetheless, psychiatry is also a set of ideologies and practices with power of another kind – the power to heal. Psychiatry has an empirically proven capacity – within particular populations (mostly middle-class Euro-Americans) and under certain circumstances (given access to appropriate services, assessment, and treatments) – to make people in great distress feel, function, and interact with other people better. Both psychotherapy and pharmacotherapy have demonstrated efficacy in responding to many of the most common mental disorders, and, in a world where physical and mental pain is such an unavoidable part of life, it is no small thing to help people suffer less.

As a result, despite the caveats outlined above, many psychiatric anthropologists choose a second approach to psychiatry: they aim to make it functional and meaningful for a broader variety of people(s). In advocating this second approach – which I will refer to as *clinically-relevant* to distinguish it from a *critical* approach, recognizing the inadequacies of these terms – anthropologists have taken on the problem of identifying the role of culture in shaping the

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[44] (Healy, 2002)
[45] (Summerfield, 1999)
[46] (Kleinman, et al., 1997a; Pederson, 2002)

experience of and response to biomedically-defined mental disorder, exploring: issues of diagnosis;[47] appropriate strategies for assessing the cross-cultural validity of psychiatric symptoms and categories;[48] issues of cultural competence in providing services to the mentally ill;[49] the role of family members in buffering and exacerbating the stressors associated with mental disorder;[50] how individuals live with and make sense of mental illness;[51] and the presence and distribution of and variation in psychiatric disorders cross-culturally.[52]

The task remains, however, of reconciling these two approaches in psychiatric anthropology. The essential antagonism appears to rest on whether psychiatry as a Western construct truly operates as a functional paradigm for easing suffering in the world. Anthropologists from both critical and clinically-relevant approaches, as well as those whose work positions them somewhere in between, are likely to agree that psychiatry is an imperfect entity with deeply flawed claims to authoritative knowledge, let alone "truth", but are likely to disagree on whether its flaws result in its doing more harm than good.

Despite this conflict, there is potential for great reciprocity between the two perspectives, to the degree that I find this tension to be productive, for two reasons. First of all, critical approaches to psychiatric anthropology tend to be very good at prioritizing what they purport to be most important about psychiatry: its cultural construction, its position in the world marketplace, the macro-level forces of which it is a product, and its capacity to serve as a

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[47] (Luhrmann, 2000; Mezzich, et al., 1999)
[48] (Barrett, 2004; Canino, et al., 1997; Kleinman, 1988b)
[49] (R. Barrett, 1996; Diaz, Fergusson, & Strauss, 2004; Santiago-Irizarry, 2001)
[50] (Jenkins, 1988, 1991, 1997; McGruder, 2004)
[51] (Corin, Thara, & Padmavati, 2004; S. Estroff, Lachicotte, Illingworth, & Johnston, 1991; S. E. Estroff, 1981; Larsen, 2004)
[52] (Guarnaccia, Good, & Kleinman, 1990; Hopper, 2004; Kleinman, 1988b)

tool for marginalization and oppression. All of these are important points for exploration and critique and, moreover, are tasks to which the methods and analytic frameworks of anthropology are well-suited. Clinically-relevant approaches in psychiatric anthropology can benefit from economic, constructivist, feminist, and critical medical anthropologies to establish a richer understanding of how psychiatry – and ethnopsychiatries – are situated within the globalizing world, and with what implications for the way psychiatric ideologies are enacted in research and practice. Equally, clinically-relevant perspectives in psychiatric anthropology are getting ever better at using interpretive, epidemiological, narrative-based, and ethnographic strategies to investigate how variation occurs in the experience of mental distress around the world, and how psychiatry can and does intersect with these experiences. Clinically-relevant approaches, on the other hand, have moved far beyond the clinic in attempting to counter the universalist assumptions of psychiatric discourse, and in doing so, have created an important, methodologically sophisticated forum in which to investigate the transactions between culturally available norms and discourses, social interactions and structures, and the individual mind.[53] So each of these two approaches, in tackling its preferred set of tasks using its preferred sets of tools, has made important contributions in furthering the field.

At the same time, I also call the tension between these two approaches a productive one because I, following Kleinman,[54] anticipate that some of the most important efforts in psychiatric anthropology will result from efforts that attempt to tie them together, bridging macro- and micro-level concerns, and positioning individual and intersubjective experiences of mental illness within the community-, national-, and global-level forces that inform them.

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[53] (Kleinman & Seeman, 2000b)
[54] (1988b)

This, then, is the task of the current work: to explore combat PTSD as it is currently being lived and understood among veterans of the wars in Iraq and Afghanistan living in South Texas, taking into account the complex interactions between individual experience, lay and professional (clinical) understandings of illness, key institutions serving this population (primarily the U.S. military and the Department of Veterans' Affairs), and the national political environment.

It is not possible to write on PTSD within anthropology without acknowledging the brilliant and insightful work of Allan Young in this area. Young's 1995 ethnography, The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder, explored the creation and early use of the diagnosis in VA settings, and came to the conclusion that the diagnosis of PTSD arose out of a confluence of political and professional notions of trauma and veterans' rights, and was thus a product of converging cultural ideas rather than a purely scientific observation of experience. The influence of Young's scholarship will be abundantly clear throughout this work. However, the question under investigation here is less the validity of PTSD as a construct and more the issue of *what combat PTSD has become since its creation* – the many ways in which it has become part of the American consciousness of war, and with what implications for the current generation of veterans. Many anthropologists, familiar with the critiques leveled at PTSD by medical historians and scholars in the field of cross-cultural mental health,[55] ask

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[55] In roughly 1995, experts began questioning the usefulness of the emphasis on trauma in shaping health and social services, citing a variety of factors: the conflation of PTSD symptoms and diagnosable levels of the disorder in epidemiological research; the difficulty of discerning the etiological relationships between memory and traumatic disorder; the inability of existing theoretical models to explain the wide range of responses to traumatic events, particularly the fact that most people experience no long-term psychological problems after trauma; the fact that most PTSD models were developed to describe the aftermath of single traumatic events, although many populations, including both veterans and refugees,

whether I believe that PTSD is real. My answer is simple: of course it is real. Hundreds of thousands of men and women in the United States and around the world will tell you that they have PTSD. PTSD is as real as their nightmares, their experiences of trauma, their anger, the disruption of their lives. This is not to say, however, that PTSD is not a socially constructed illness – it is that too.

To my mind, PTSD represents one of the many possible names given to certain kinds of suffering. It is a historical product, in that it emerged from a certain time and place, and it seems likely that the diagnosis will continue to pass into new forms (quite possibly with new names) over time. The question of whether PTSD is "real" or a "pseudodisease", then, seems less helpful than the question of whether PTSD represents the best possible description of post-traumatic suffering, given that the way we describe such suffering plays a profound role in our efforts to provide healing and respite. The validity of PTSD is primarily important in terms of whether or not the construct contributes to or interferes with the well-being of those in

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have lived through multiple traumas; and the cultural assumptions imbedded in the major therapeutic responses to PTSD, which focused on talking about and "working through" traumas, in contrast with the value placed in many non-Western cultures on moving forward and forgetting the past (Englund, 1998b; Ingleby, 2005; Summerfield, 1999; Young, 1995).

In an important work, Daniel Becker (1995) summarized several additional concerns with the diagnosis of PTSD as a clinical response to victims of trauma. In his view, individuals who have suffered human rights violations cannot usually be said to be "post" trauma, which is often "cumulative and continuous." He rejected the word "disorder" to describe the response of victims to the actions of their perpetrators[55], and noted that for many of his Chilean patients, "it makes an enormous difference that we regard them less as individually disturbed and more as persons suffering the consequences of a disturbed society" (Becker, 1995: 104). In addition, Becker pointed out the overlap between mental and physical symptoms related to trauma, which he found to be poorly described by the symptom clusters of the DSM, and poorly treated by an emphasis on individual pathology rather than "survivor families" and a dependence on "social process." Becker's concerns have been echoed eloquently by scholars like Derek Summerfield (1999; 2000a; 2001) and Duncan Pederson (2002).

distress. This is a question discussed in the final chapter of the dissertation, after much consideration of that distress and the many cultural and other factors that shape it.

In the intervening pages, rather than returning to familiar arguments weighing the pros and cons of PTSD as a diagnosis, I focus instead on examining how the diagnosis of PTSD – imperfect as it may be – has taken on life and meaning in the world beyond the clinic, taking shape in the lives of veterans suffering from post-war distress. These experiences are then analyzed for how they reveal the influence of social, professional, political, and economic forces at play and at odds across multiple venues of society.

Guiding Ethnographies

Anthropology's greatest strength as a discipline, to my mind, is its ability to elucidate the connections between events and processes ongoing at multiple levels of culture and society. So in designing an anthropological project capable of untangling those events and processes with relevance for the phenomenon of mental illness, I have placed a central focus on examining how social and cultural entities interact with individual beings. Among the many works that have inspired the current research,[56] I have found Arthur Kleinman's Social Origins of Distress and Disease to be an exceptional model for this effort because it cogently integrates so many variables influencing the experience of depression in China: local and national political structures; social and intersubjective conflicts; individual life histories; ethnomedical classifications of distress and disease; and the role of meaning-making in organizing experience.

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[56] (from among the many good ones, see also R. Barrett, 1996; R. R. Desjarlais, 1997; S. E. Estroff, 1981; T. D. O'Nell, 1996; Scheper-Hughes, 2001; Young, 1995)

In so doing, Kleinman is able to reveal important possibilities for understanding the universal processes by which the task of moving through life is managed by individuals and groups.

But an anthropologist's efforts need not be so broad in order to inform a meaningful understanding of mental health and illness. Anthropologists should strive to produce knowledge with relevance for universal understandings of the human condition, but understandings of specific variables and relationships operating within more bounded inquiries are an essential step in developing generalizable theory. Tanya Luhrmann's ethnography of American psychiatry, for example, provides important insight into how ethnomedical knowledge systems are produced and enacted, and with what consequences for individual actors functioning within them, both as patients and healers. Unni Wikan's work on experiences of suffering in Bali, aptly titled Managing Turbulent Hearts, is striking for the way it illuminates how much is at stake in moving as a feeling and thinking agent through webs of cultural expectations, sociomoral engagement, and events beyond one's own control. Both of these works are valuable for their focus on particular aspects of the movement of cultural and individual entities through time and space, and for the contribution they make to our knowledge of how mental illness is configured in this process.

The overarching task for an ethnography of mental health and illness, then, is to explore in-depth those specific concerns (e.g. ethnomedical systems of knowledge and practice, cultural conceptions of agency and personhood, and/or personal histories) that have a bearing on central questions in the larger project (such as how culture shapes the experience and presentation of physical and psychological symptoms, how idioms of distress come to be embodied, or why some individuals are more resilient to life stresses than others) while keeping

in mind how multiple levels of the social and cultural world may dynamically interact to produce locally constituted experiences of well-being and distress.

Goals for the Current Work

Informed by these goals, the current work aims to explore the intersection between three essential concerns reflected in the ethnographies outlined above.

First, following Kleinman's analysis of the impact of China's Cultural Revolution on the well-being of individuals, I examine how social and political histories *(resulting in multinational military conflict)* come to be embodied in experiences of individual suffering *(in the form of post-combat distress)*. Eighteen months of fieldwork in San Antonio, Texas have allowed me to document how these veterans and those in their social worlds experience and make sense of combat PTSD, a highly controversial diagnosis to which they were made vulnerable by their service in the equally controversial "Global War on Terror." The social suffering and trauma literatures have contributed a great deal to our understandings of how exposure to political violence impacts personal and social well-being,[57] but much remains to be learned about how individuals' perspectives on the meanings of such violence,[58] let alone their potential role as perpetrators within it,[59] influence levels and types of distress in combat's aftermath. Historically-sensitive work has made a significant contribution to the understanding of how individuals position their own experiences of stress, trauma, and loss within collectively shared

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[57] (Das, et al., 2001; Das, et al., 2000; Dickson-Gomez, 2003; Herman, 1992; Jenkins, 1998; Kleinman, et al., 1997b; Kleinman & Desjarlais, 1995; Loughrey, Bell, Kee, Roddy, & Curran, 1988; Mollica, et al., 1990; T. O'Nell, 1999; Robben & Suarez-Orozco, 2000; Warren, 1993a, 1993b)
[58] (Janoff-Bulman, 1992; Magomed-Eminov, 1997; Shay, 1994)
[59] (Grossman, 1995; MacNair, 2002)

histories.[60] In clarifying how veterans understand their experiences of PTSD illness in relation to their involvement in military service, and how they experience and present psychological and somatic symptoms of combat-related distress, I aim to enrich our understanding of how lived history is embodied in personal suffering.[61]

Second, following Luhrmann's investigation of the production, diffusion, and enactment of knowledge systems in American psychiatry, I consider how lay and professional ethnopsychiatries *(with their constructions of trauma and PTSD)* influence the experience of and response to mental illness *(in terms of particular PTSD symptoms, behavioral sequalae, treatment-seeking and recommendations, etc.)*. As noted, Allan Young has conducted a detailed deconstruction of the political and professional processes by which PTSD came to be formalized as a psychiatric diagnosis,[62] but thus far anthropology has failed to explore how ethnopsychiatric notions of trauma and PTSD have been taken up in popular American discourse, an issue of particular relevance when one considers how such lay conceptualizations may impact experiences and expectations of trauma-related distress, care-seeking, and coping strategies. Moreover, although it has been hypothesized that significant differences in risk for developing PTSD between White and Hispanic veterans may be explained by cultural differences in the conceptualization of fright and stress,[63] this speculation has yet to be ethnographically explored. By addressing these concerns, this intended research contributes to our knowledge of how

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[60] (Caruth, 1996; Lomsky-Feder, 2004; T. D. O'Nell, 1996; Suarez-Orozco & Robben, 2000)
[61] (Kleinman & Kleinman, 1994)
[62] (Young, 1995)
[63] (G. N. Marshall & Orlando, 2002; Ruef, et al., 2000)

individuals make sense of a complex array of available discourses in the process of living with mental illness.[64]

Third, following Wikan's careful account of agency and feeling-thought in Bali, I explore how individual and intersubjective efforts to manage and make meaning of distress *(e.g. through illness narratives and treatment-seeking)*[65] are informed by cultural norms for personhood and role expectations *(e.g. as shaped by gender and ethnicity)*.[66] Past research has demonstrated that family perceptions of a member's mental illness, as well as cultural norms for levels of intimacy and interdependence in family life, have consequences for the ways in which the illness is discussed and made sense of, and in which treatment is sought and care provided.[67] I will also discuss interactions within the family around issues such as conflict created by the veteran's distress or disruptive behaviors, revealing how these interactions are shaped by understandings of trauma-related illness and by expectations of what an adult male should do and be as a participant in family life.[68]

In exploring these issues, I intend this work to contribute to a meaningful and productive ethnography of mental health and illness, with relevance for informing both anthropological theory and health-promoting practice.

Thinking in terms of trauma more specifically, this dissertation examines PTSD as an illness category in the contemporary U.S. Thanks in large part to Allan Young,[69] the medicalization of combat trauma as PTSD has become a classic example of how suffering is

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[64] (Larsen, 2004)
[65] (Kleinman, 1988a)
[66] (Corin, et al., 2004)
[67] (Corin, et al., 2004; B. J. Good & Subandi, 2004; Jenkins, 1988, 1991, 1997; Kleinman, 1988b)
[68] (Connell, 2005[1995]; Gilmore, 1990; M. C. Gutmann, 1997)
[69] (Young, 1995)

interpreted and negotiated by public, political, and professional actors. Indeed, screening for PTSD has become a predictable feature of post-conflict and post-disaster humanitarian response efforts around the world,[70] as well as a topic of considerable attention and debate in the anthropological literature.

An unfortunate feature of this literature, however, has been a tendency at times to conflate discussions of trauma (exposure to a horrific event) with suffering (a state of generalized individual or social distress) and with PTSD, which is a biomedical category describing a cluster of symptoms so severe that they result in considerable functional impairment, and which only occurs among a minority of those exposed to trauma. It is important to be clear in distinguishing these terms because this dissertation deals for the most part with combat PTSD in particular, rather than with trauma or suffering as they have been experienced more generally by servicemen and women in the course of the conflicts in Iraq and Afghanistan.

Throughout the current work, I also respond to another tendency of the anthropological literature on trauma among post-conflict populations, which is to speak of "PTSD" as a monolithic Western biomedical construct, rather than a set of fluid, contested ethnopsychiatric notions that are continuously negotiated across lay and professional realms, and within both public and private discourses. This is something of a puzzling gap, given that we have quite good phenomenological accounts of trauma and suffering.[71] Although certainly authoritative in their impact on professionalized global mental health, American understandings of combat PTSD – in terms of what PTSD is, what it represents as far as processes within the body and mind, and

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[70] (J. Breslau, 2000)
[71] (Biehl, 2005; Nordstrom, 1997; Wikan, 1990)

what actions should be taken in response – are heterogeneous and dynamic, emerging and re-emerging in dialogue with shifting notions of military service, combat trauma, and what it means to be a veteran in contemporary American society. By bringing both clinical and experiential analyses to bear on the study of PTSD – and in thus avoiding the temptation to view Westerns notions of PTSD as static and hegemonic – it becomes possible to elicit more nuanced comparisons of trauma and coping, with relevance for the cross-cultural study of post-traumatic distress more broadly.

Glossary of Abbreviations

Appendix B

APA – American Psychiatric Association

BAMC – Brooke Army Medical Center

BDU – Battle Dress Uniforms, aka “fatigues”

CBT – Cognitive Behavioral Therapy

C&P – Compensation and Pension Board of the VA, or the C&P exam used to establish a record of veterans service-related health conditions

COSC – Combat Operational Stress Control

CSC - Combat Stress Control

CSR – Combat Stress Reaction

DOD – Department of Defense

ESTs – Evidence Supported Therapies

FOB – Forward Operating Base

HR – Human Remains

IED – Improvised Explosive Device

MRE – Meals Ready to Eat

OEF/OIF – Operation Enduring Freedom/Operation Iraqi Freedom, an abbreviation commonly used within the military and the VA to refer to veterans of military operations in Afghanistan and Iraq, respectively

PDHA/PDHRA – Post-Deployment Health Assessment, Post-Deployment Health Reassessment

PDS – Post-Deployment Study, the study whose findings are presented in this dissertation

PE – Prolonged Exposure Therapy

PFT – Physical Fitness Test

PTSD – Post-Traumatic Stress Disorder

RPG – Rocket-Propelled Grenade

THT – Tactical Human Teams

VA – Department of Veterans' Affairs (the overarching national agency in charge of veteran-related healthcare, benefits, and compensation)

VBA – Veterans' Benefits Administration, the unique branch of the VA devoted to overseeing compensation and other benefits for veterans

VHA – Veterans' Healthcare Administration, the unique branch of the VA devoted to providing healthcare to veterans

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