

Post Traumatic Stress Disorder in Gulf War Three Veterans

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Post traumatic stress disorder, or PTSD, is a psychological disorder that remains poorly understood by many medical professionals. PTSD has been documented throughout various wars including the most recent Gulf War. Although PTSD may be diagnosed in a number of individuals, the causes and symptoms of PTSD in each individual vary greatly. Due to the different levels of severity, wide range of stressors, and overlap with other mental disorders, PTSD is difficult to diagnose and thus, difficult to treat. In regard to women, treatment plans should take into consideration that sexual assault and rape are also common causes of PTSD in service women in Iraq. Treatment coupled with support from friends and family may ease the burden of PTSD. The presence of a wide support network is significant in a veteran's reintegration into civilian life. Unfortunately, despite the fact that PTSD has been prevalent in wars, especially in Gulf War Three, little attention has been given to treating PTSD, leaving soldiers with limited options in getting the medical care that they need and deserve. In order to help current soldiers and veterans with PTSD, the Department of Veteran Affairs needs to take a more progressive stance on PTSD and commit more resources to its research.

In 1980, the American Psychiatric Association acknowledged PTSD as a psychological disorder (Ballinger 100). PTSD is commonly defined as an anxiety disorder that a person develops when he/she is exposed to "a traumatic event that causes feelings of extreme fear, horror, or helplessness" (Ozer and Weiss 169). Traumatic events include situations that involve "death, serious injury, or threat of death" (169). Several different scenarios can trigger these kinds of feelings. In regard to war, common causes of PTSD include witnessing injury, mutilation, suffering of others, and the "grotesque and seemingly meaningless" death of people, including both combatants and civilians (Kelly 102). Not every service member who witnesses

such events will develop the disorder, but the violent nature of war increases the chances that PTSD will result.

Although PTSD was only officially recognized in 1980, it has been recorded in veterans in wars throughout the twentieth century. Research on PTSD dates all the way back to the end of World War II, when tens of thousands of soldiers experienced symptoms common to PTSD, such as “depression, survivor guilt, recurring nightmares...[and] exaggerated startle responses” (Childers 8). Despite the numerous World War II veterans exhibiting signs of PTSD, little research was conducted on it because military personnel and doctors looked down upon PTSD sufferers, as “the image presented by psychologically destroyed men was intolerable in American eyes” (Fassin and Rechtman 69). This left veterans in a precarious situation where “the courage and sense of sacrifice of these men was clearly portrayed ...but equally apparent was the fact that some of them were utterly destroyed” (69). While some veterans did receive treatment during this time, countless others were left to cope with these on their own.

Finally, a breakthrough in PTSD research occurred after the Vietnam War. Veterans returned home displaying many symptoms that World War II veterans had experienced: depression, anger, sleeplessness, flashbacks, guilt, and other mental and temperamental disorders (Kelly 104). Overwhelmed by the numbers of veterans experiencing these symptoms, psychiatrists and medics in the military began to pay closer attention to the symptoms. Researchers eventually noticed a pattern (20). Studies were conducted on the nature of these symptoms, allowing the research base to grow and develop. Ultimately, approximately 31percent of male and 26 percent of female Vietnam veterans were reported to have PTSD (Ozer and Weiss 169). As these facts became public through the media, more and more attention was drawn to PTSD. From 1972-1979, the Senate Veterans Affairs Committee (SVAC) submitted

various pieces of legislation to Congress, all of which asked for the recognition and treatment of PTSD (Kelly 3). After seven years, the legislation passed, which led to the APA's recognition of PTSD as a disorder. In the end, "PTSD gained much of its currency through the public awareness of the psychological toll of the Vietnam War upon veterans" and, without the determination of the veterans and the SVAC to bring this issue to light, proper recognition of PTSD might not have arrived until many years later (Ballinger 108).

Just as PTSD was common in past wars, the number of GW3 veterans diagnosed with PTSD is staggering. According to a 2008 study by the California Community Foundation, one in five service members will develop PTSD (Burke 5). The numbers can be further broken down according to which country the veteran served in: 15.6 percent to 17.1 percent of servicemen are diagnosed after returning from Iraq, while 11.2 percent are diagnosed after duty in Afghanistan (Marmar 494). Although no study has explained why the PTSD rates are lower in Afghanistan than in Iraq, other trends are being revealed as more studies are conducted. For example, veterans under the age of 25 have the highest rates of PTSD (Marmar 496). Considering the age and numbers of veterans being diagnosed, PTSD levels have not dropped nor have they dramatically changed in this war compared to previous wars.

Although PTSD is a situational disorder that each person experiences differently, there are several common symptoms attributed to it. These symptoms include "excessive autonomic arousal, hyperalertness, exaggerated startle reactions, difficulty falling asleep, and the feeling of being on the verge of losing control" (Sonnenberg 20). Other symptoms resemble anxiety problems, such as depression, disinterest in activities and hobbies, detachment from the outside world, and the inability to maintain relationships. As Sonnenberg explains, PTSD leaves a veteran feeling like "life had lost its meaning" (20).

One of the more painful symptoms of PTSD is re-experiencing trauma. This event is “usually repetitive, is not voluntarily controllable, is emotionally painful, and either exactly or closely reproduces actual traumatic experiences in whole or in part.” (Sonnenberg 103). These moments can occur either when a veteran is awake, or through a dream during the veteran’s sleep. When awake, they can be caused by anything that reminds the veteran of the traumatic instance, such as an image, sound, or smell. Thus, they represent the “impossibility of forgetting those same indescribable horrors of war. The flood of memories might be triggered by a putrid smell or a loud bang and might manifest itself in recurring nightmares” (Ballinger 109). In either form, “the most common form of re-experience is a sudden vivid memory which takes over full attention and is accompanied by the emotions which occurred during the original experience” (Sonnenberg 103).

Not only is the re-experience itself painful, but it can debilitate a veteran in his/her everyday life. Gil, who served in Iraq in the Army in 2007 explains re-experiencing trauma after returning to the United States,

I couldn’t sleep for a long time mainly because I had no proper sleep cycle and I wasn’t being exerted as much as I was [in combat]. I had a lot of energy pent up. I knew I had Post Traumatic Stress Disorder because I would often re-live events in dreams and wake up sweating often. And still to this day, I am very paranoid about a lot only because of the traumatic experiences. I’m paranoid about everything (Gil 2010).

Not only does PTSD have many symptoms, but these symptoms also range in severity. Some veterans diagnosed with PTSD, such as Fernando, reported very little stress. After serving two tours in Iraq from June 2006 until June 2010, Fernando began to experience bouts of sleeplessness. While he experienced insomnia, the symptoms only bothered him in certain situations, mainly ones that involved loud noises that resembled the sound of gunshots and explosions. He explains,

After a thunderstorm, I tried to go to sleep, but I couldn't sleep for a week after it. Now I'm cool. Fourth of the July was [also] pretty awkward, but now I'm fine. It comes in waves for me; I could cope with it. I won't just wake up and strangle someone. If it were affecting me too much, then I'd probably whine about it. I'm not hurting anyone and I don't need to hurt anyone (Fernando 2010).

However, other veterans experienced more severe symptoms. After being deployed in 2003, Rebecca felt “mentally all over the place” and depressed for several months, which debilitated her in her day-to-day life (Rebecca 2010). The differences between Fernando and Rebecca illustrate the diverse reactions that veterans experience after returning from war. While both suffered from common PTSD symptoms, veterans may experience these symptoms in different ways and intensities.

While the main causes and severity of these symptoms rely on events that have been experienced and witnessed, such as death and torture, other stressors also have been linked to PTSD. One of the main stressors is age: service men and women who are young are more likely to develop PTSD than older service members. This was a common occurrence in Vietnam. The soldiers who went into battle were young, and they were not “ideologically or emotionally prepared to face the complex and often surreal nature of jungle combat against a resilient, tenacious, resourceful and determined enemy” (Kelly 140). The same trend appears in GW3. According to Marmar, “young men and women returning from Afghanistan and Iraq service with warzone-related PTSD and related mental health problems struggle to confront these problems” (Marmar 496). With these trends in mind, one can conclude that the younger a veteran is, the more likely it is that he or she will develop PTSD.

Another stressor that can lead to PTSD is injury. Veterans who received injuries and developed physical side effects, such as Traumatic Brain Injury (TBI), were more likely to develop PTSD. A study conducted on 2,525 army members in Iraq revealed that 16.2 percent of

those who were injured without falling unconscious developed PTSD, while 43.9 percent of those who did lose consciousness developed PTSD. This illustrates a correlation between the severity of a physical injury and PTSD development. Rebecca, who was injured in combat two months after being deployed, explains her experience with coping with an injury and PTSD,

I was involved in an explosion that knocked me out. I don't remember anything about the explosion, just coming to and being in pain. My ears were ringing - like the movie *Saving Private Ryan* when he gets in an explosion; you can't hear anything except sounds like rumbling. It was like, "What the hell just happened?" Inside the compound in a far corner, there was a mortar attack. Thankfully I wasn't walking towards it, but I was still in area. I flew back and hit a concrete barrier, hit my head, and landed (Rebecca 2010).

After being injured, she felt her mood begin to shift. She describes, "I was really angry about everything. I wasn't going to say anything, I just wanted to go home and be left alone. It eats you up and you blame yourself." While her injury was not the sole cause of her PTSD, the unfortunate circumstances added to the trauma that Rebecca endured.

A third stressor that psychiatrists link with PTSD is a feeling of uncertainty. This stressor played a prominent role in GW2, where soldiers were deployed without proper knowledge of their mission. Robert Gifford explains, "The main stressor identified in September-October 1990 was the uncertainty of the tour length, since soldiers had no idea whether they would be there for a few more weeks or, at the other extreme, possibly a year or more. [...] This feeling of frustration at being stranded in the desert with no clear end in sight was combined with a general lack of information about what was occurring at higher levels, what plans were being made, and what the overall status of the operation was" (Gifford 586, 589). These and earlier descriptions imply that a feeling of helplessness lies at the root of these stressors. A feeling of uncertainty follows some servicemen in GW3, as well, including Gil. When Gil arrived in Iraq, he was unaware of many important details, which left him feeling anxious. He explains,

"I didn't know where I was, on base in the desert. No one was told where we were; PFCs

(private first class) were kept in the dark. It was only the chain of command that knew where we were. I was too busy to find out details. Just like basic training, we had to follow orders. We were not paid to think or ask question, just execute. I was worried about making it back okay in one piece, what I was going to be doing daily, how many hours I would sleep, whether I was getting fed, or attacked. Too many things running through my mind. Everyone else is on edge, and you don't want to approach your chain of command with those questions because they get annoyed.”

By refusing to provide soldiers with adequate information about their surroundings and the war that they are fighting, U.S. military leaders contribute to the development of PTSD.

Although these symptoms and stressors may persist for many months, a veteran may not know that he/she has PTSD. According to Sonnenberg, “often the veteran was quite unaware of the syndrome to which he or she had fallen prey and unaware of its origin in the traumatic experience of combat” (20). One reason why some veterans are not conscious of these symptoms is because they may fall into a state of denial where they are unable to process and accept the events they have seen. Kelly explains, “until the individual successfully assimilates the trauma, he or she experiences psychic overload, a state in which the nature, intensity, and meaning of the experiences are not readily understandable in terms of the existing conceptual schemata of reality” (107). If veterans are unable to acknowledge these problems, there is little chance that they will seek help. Ultimately, not only do the symptoms cause the victims pain, but their denial also prevents these problems from being addressed.

PTSD is difficult to diagnose due to variation in symptoms, severity and the similarity of PTSD symptoms to the symptoms of anxiety and mood disorders. Three of seventeen PTSD symptoms overlap with symptoms of major depressive disorder, which affects the reliability of diagnoses. However, there are some hallmark symptoms of PTSD: “re-experience trauma, flashbacks, nightmares, trauma-related intrusive thoughts, heightened arousal” (Kimerling 122). One must look at the combination of symptoms present in order to properly distinguish disorders

from each other. To be diagnosed with PTSD, a person must show evidence of multiple PTSD symptoms. For example, if poor concentration is paired with a startle response, then the person most likely has PTSD, whereas if he exhibits poor concentration and weight gain, he is more likely to have a depressive disorder (Kimerling 122).

According to the VA's website, a PTSD evaluation measures "how you felt or acted after going through a traumatic event." To be diagnosed with PTSD, a person must experience a traumatic event. A typical screening for PTSD consists of a short list of seven questions, although the screenings may entail eight or more one-hour sessions for "legal reasons or disability claims" (VA). The most common test for PTSD is the Clinician Administered PTSD Scale. It focuses on how often a patient has symptoms of PTSD, and the intensity of the symptoms. Physician's Assistant John Henry gives an informal description of the assessment a soldier goes through post-deployment:

Everybody that comes back from Iraq...[goes] through an initial screening. You go through medical screening. That's where you see a PA or a physician and you tell him whatever kind of injuries or issues you had over there. Because you've been deployed you get put into a consult. You are first come for the first appointment. People with undiagnosed mental issues, like PTSD type stuff, that's their route to get seen if they didn't want to deal with it while they were in Iraq. [They] might be more forthcoming now[...]You may get seen immediately or within the next week. You get a priority. This screening after Iraq is where you're provided to say that kind of stuff. You're not in the middle of a big room. If you don't say anything, then it's hard to tell[...] (John Henry 2010).

Assuming a soldier is able to talk to a medical professional openly and receive help for PTSD, there are various treatments available. Cognitive Behavioral Therapy, or CBT, is where the patient "undergoes repeated and prolonged confrontation with anxiety-evoking objects or situations, until anxiety is gradually reduced through the process of extinction/habituation" He become desensitized to the triggers of anxiety (Jenkins). Other treatments include group and

family therapy. In a group with others who have had similar experiences, a soldier may be more open to sharing his or her personal traumas. The goals of group therapy are for the soldiers to build relationships with others, and self-confidence and trust in themselves as they deal with PTSD. Another option is pharmacological treatment, also known as “drug therapy.”

Some patients may feel more comfortable taking medication than taking the CBT route because it allows them to avoid confrontation with their traumatic experiences. However, the negative consequences of this type of therapy include the risk of dependency on the drugs, while the question remains whether the drugs are a healthy long-term solution. Medication may not be the best option for the soldier but is occasionally prescribed as compensation for one-on-one therapy with a psychiatrist who wants to alleviate his patient backlog problem. One cause of the backlog is the decline of medical professionals in the military. “Between 2003 and 2007, the number of active duty Air Force mental health professionals dropped by 20 percent, the Navy reported a 15 percent decline between 2003 and 2006, and the Army an 8 percent drop between 2003 and 2005” (Glantz 96). As medical professionals leave the military, service members may experience greater difficulty in obtaining treatment and may not receive the medical help they need.

The availability of several treatment options is irrelevant if the bureaucracy isn’t primarily concerned with the veterans’ well-being in the first place. Aaron Glantz, author of *The War Comes Home*, interviewed Specialist James Eggemeyer about his struggle with the VA to claim his disability benefits. Eggemeyer filed a disability claim in December of 2006 and waited. Eggemeyer recounts the lengthy process:

They said that I was at the rating board, that they had all the information and all the medical evidence[...]You should have your decision in no time. Well about a week after that[...]they said: you’re missing these three forms. You need to send them in for your file in order for them to be rated[...]Three days later, I called them...they said they had

everything they needed and I would be rated...and get my disability established. Well I called them up yesterday and it's back at the developmental stages[...]they told me they need to gather more medical information" (Glantz 110-11).

Eggemeyer finally heard from the claims official in September of 2007. The average amount of time a veteran must wait for his or her claim to be heard is about six months (Glantz 111). That Eggemeyer was told that the VA needed more information is not surprising. The system appears to be more concerned with detecting fraudulent claims for medical benefits than with providing them. Glantz notes that "a veteran applying for compensation for post-traumatic stress disorder must submit a twenty-six page form" and must present evidence of the traumatic event that he experienced. Unfortunately, in a war zone, records of the time and place a traumatic incident has occurred may be scarce; obtaining an official record is even more difficult if the event consists of assault by a superior. As Physician's Assistant John Henry puts it: "They put everyone on a plane that they can. There needs to be a good reason for you not to go and it needs to be medically documented, if not, you get on the plane" (John Henry 2010). Furthermore, soldiers' willingness to come forward about mental or physical injury may be influenced by social perception. Complaints can make a soldier appear cowardly, weak or cause him or her to be accused of malingering or even lying. Rebecca, our interviewee, expressed bitter sentiments towards the army psychiatrist to whom she was referred.

They were[...]cold. When I was going through the process of getting out, I talked to a psychiatrist who was an asshole. He accused me of lying...yeah, he was a real jerk. I hate him. He tried to say things didn't happen. I guess they didn't want what happened to get out because it happens to so many women (Rebecca 2010).

Another way that soldiers can be denied their benefits is by being diagnosed with personality disorders, which are viewed as pre-existing conditions by the military. Thus, soldiers with supposed personality disorders may "be dishonorably discharged for lying about their

mental health when joining the military” (Glantz 198). There are many advantages to diagnosing a soldier with a personality disorder as opposed to PTSD. Personality disorders better serve the military’s needs. If someone is discharged with a personality disorder, he or she can be replaced with a fresh soldier and compensation is not required from the VA.

If one were to give some recommendations and note what was necessary for veterans to receive their benefits, they would include but not be limited to: streamlining the application or disability claims process, not re-deploying soldiers who have been diagnosed with PTSD to avoid the exacerbation of their symptoms, and providing the necessary resources for mental health professionals so that they can provide quality care to veterans.

In regard to medical care for female war veterans, other considerations need to be taken into account because their traumas tend to be gender-specific. Also, as time goes on, the number of women in the military rises. “The large number of female soldiers on the battlefield is one of the key differences between the Iraq War and previous conflicts... In March 2007, one of every ten U.S. soldiers in Iraq was female” (Glantz 20). Despite these numbers, women are still outnumbered by their male counterparts and are especially vulnerable to sexual assault and harassment. “Research on exposure to specific [traumatic] events indicates that men are exposed to combat, mugging, or beating more often, while women experience higher rates of rape and sexual assault” (Gherke 72). Many of these acts of rape and sexual assault may cause a victim to be afflicted with PTSD. According to the U.S. Department of Veterans’ Affairs, 20 percent of women veterans from the Iraq and Afghanistan War have been diagnosed with PTSD. Rebecca, one of the interviewees, was able to give us a personal account of her experiences as a soldier participating in Operation Iraqi Freedom. When asked if it was difficult to adjust, she said:

It wasn’t scary at first. It was actually really interesting. I was young so I didn’t know a lot. At first, it was really really awesome because I got to see things I had never seen

before. It wasn't hard to adjust until probably three months into it. I had a lot of problems with the guys because I was one of the only females. They all just kind of gravitate toward one girl. It's kinda creepy. Even the higher ups. (Rebecca 2010).

The VA identifies this type of harassment as "military sexual trauma." Military sexual trauma (MST) is defined as "any kind of unwanted sexual attention," and it is listed as one of many stressors that women face in the military (VA website). More serious causes of PTSD in women such as rape also have to be taken into consideration. Rape was eventually recognized in the 1980's as a traumatic event that has potential to cause PTSD (Kimerling 117). Research had begun to show that women who were victims of sexual assault developed symptoms that were similar to symptoms of PTSD exhibited by men who had been in combat. Rebecca's experiences would seem to confirm these findings. Rebecca recounts how

[...]in February, an incident happened with another soldier, where he forced himself upon me. That was really really[...]Yeah. That's when I kind of lost it. I didn't leave and I didn't tell anyone about it for a long time...He threatened to kill me (Rebecca 2010).

Rebecca was a private and the perpetrator was a specialist. Since he outranked her, the specialist told Rebecca that if she reported him, he'd not only kill her but that he'd get away with it. The abuse of authority on the part of superiors is especially problematic since it causes erosion in trust on the soldier's part and eliminates the opportunity to remedy such situations. If there is no superior to whom a female soldier may report, then she is essentially trapped in an unpleasant quandary while the perpetrator is not held accountable or punished. Furthermore, the perpetrator continues to be in the vicinity of the victim, which only serves to jeopardize and threaten the victim's well-being. In Rebecca's case, the sexual harassment encounter continued to affect her mental health. Although she was required to carry a loaded weapon on her persons at all times, she had to take preventative measures so that she wouldn't harm the specialist.

I thought about killing him a few times... I tried to stay away from him and I tried to be around people I trusted. It was really tough...seeing him all the time and not being able to say anything...We always had weapons on us. You even had to sleep with them. I unloaded all the bullets because I didn't think it was safe for me to walk around with that [her weapon] because I felt like I was going to hurt that guy...and kill people in the military. That's when it was time to go...

The focus on the type of trauma women experience is particularly significant because women tend to be more reactive than men to traumatic events that have a negative social impact. According to Kimerling, women tend to focus on interpersonal relationships and define themselves through their relationships with others. Men, on the other hand, tend to prioritize societal perception of their masculinity higher than their personal relationships. As a result, some women blame themselves for the violence committed against them in an attempt to salvage their social connections. In regard to Rebecca, the way in which some of the male soldiers treated her affected her relationships with other female soldiers, which only served to exacerbate her situation.

It [the incident with the specialist] was pretty bad[...]honestly, because of the way the guys were with me, the girls didn't like me. I didn't have any girl friends there. They'd accuse me of flirting[...] All the girls loved the photographer. He asked me to hang out[...]and I said I'd be his friend and hang out with but not romantically and lot of the girls were upset, accused me of stealing him...(Rebecca 2010).

Although the book, *Who Gets PTSD?*, analyzes PTSD among “protective services professionals (such as law enforcement, fire and emergency services),” some conclusions can easily be applied to the military and help to explain why women's social networks in the military, and hence their support systems, are lacking (3). Gherke argues, “gender differences in reactions to a traumatic experience may be explained by its gender-specific attributes[...]" (72). Policing may be one of the most masculinized civilian occupations but the military could be considered equally or even more masculinized. One gender-specific attribute or stereotype is the

“women as risks” argument. If males were to rely on their female counterparts, they would be putting themselves at risk since women can’t “physically...support them in dangerous situations and protect them in return” (Gherke 73). Therefore, females cannot make or find a place for themselves in such a masculinized context. The aforementioned stereotype prevents them from fully integrating into the military and creating relationships with male soldiers. “The availability of social support and the capacity to make use of it can protect traumatized persons from developing PTSD” and a female’s perception of social support “influences the impacts of a trauma and the coping process” (Gherke 73).

Coping with PTSD is challenging. It is easier if a social and familial support network is present. As John Henry explains,

The Vietnam people were spit on and called baby killers. That’s one good thing about Iraq, you are celebrated. You come back to the gym and your family is there, the patriotic songs are playing. The process of coming back is much more easier. You come back and hand in your weapon and have a quick ceremony and then you go to your family (John Henry 2010).

An established family structure also keeps soldiers balanced while they are overseas as Gil explained,

I was there and nothing else mattered but making it back home alive[...] Anytime I would think about it I’d try to stop thinking about it [...]I’m here because someone wants oil. I’m going to lose my life because someone wants oil cheaper. I am going to die because of someone’s careless mistake. I did careless stuff but nothing that would endanger someone. The important thing that I had to do was just maintain a positive attitude and stay strong. There were times you just wanted to get the hell out... one tough thing that everyday you always thought [is] how you were experiencing such difficulties and hardships and tragedies. You didn’t have time to communicate with family and it was sort of like you start to lose everything. You have a girlfriend, or a wife, or family, and everyone forgets about you when you are over there. They continue living their lives even though you are off doing something else; it was difficult being separated from the world. [...] [It was] overwhelming the times you did have downtime [...]the times you couldn’t evade your thoughts because you had no distractions, thoughts about how soon would we have to do another mission? How soon could I call home? What is my family doing? Will I ever see them again? How I could become more at peace with myself. I would write my family whenever I could have some free time. I spent a lot of time praying.... and thinking about

what I'd do if I'd encounter certain situations. If I had a POA, a plan of action, I'd be able to execute what I thought instead of freezing up (Gil 2010).

Gil, like other soldiers with minimal contact with family members, remembers his family during his free time as a constant reason to stay alive. He has people to return home to and to fight for during wartime. There is a positive attitude towards war when a soldier has a good family structure back at home. Gil, even after his traumatic experience, wants to return to the front lines today. His comments demonstrate how an established family structure can keep a soldier balanced while he is overseas but upon returning home, he feels a lack of purpose. His balance is thrown off being back at home with his family while his Army brothers are still fighting overseas.

Don't get me wrong, I wouldn't hesitate to preserve myself or any of my friends if, God forbid, I were ever faced with a situation. I wouldn't hesitate in killing someone else to save a life that is good and innocent.[...] In all our training there were times where we'd be extremely uncomfortable but we were told to wear gear because it would save you. If we were ever killed in action without gear, our family would be denied insurance policies. It was complacency [that I took off my gear], just foolish, but then again, I was only eighteen or nineteen. I don't even remember. I don't even remember the year I went in. It just happens so quickly. A military career happened so quickly, now thinking about it. I am going back (Gil 2010).

The sense of loyalty to a country and fellow fighters, and the desire to return to potentially trauma-inducing environments that is shared by many soldiers was first documented following World War I. Dr. William H.R Rivers of Cambridge University was assigned to work at Craiglockhart Hospital in Scotland. The hospital was commissioned by the British military to treat soldiers who were victims of "shell shock". One of the hospital's most famous patients, poet Siegfried Sassoon, wrote a protest to his commanding officer, a famous letter entitled "A Soldier's Declaration." In the letter, Sassoon protested against England's actions in the war. He hoped for a court-martial of his commanding officer, but his letter, published in the *London Times* and read aloud in the House of Commons, was dismissed as an irrelevant gesture made by

a soldier who needed psychiatric care. Sassoon was sent to Craiglockhart. Dr. Rivers helped Sassoon with his nightmares and the effects of PTSD but he was puzzled when Sassoon re-enlisted. Sassoon “chose to return to the front; he chose to risk provoking a recurrence of his frightful illness out of a sense to loyalty to the men which he served.” As Herver Spiegel, a front-line psychiatrist wrote at the beginning of World War II, “what enabled them to attack and attack, week after week in mud, rain, dust and heat? It seemed that the answer lay not in any negative drive but in a positive one. It was love more than hate that propelled these men. They seemed to be fighting for somebody rather than against somebody” (Coleman 35-37). The pressure that war places on soldiers to fight for their buddies and the liberty of their families, makes their voluntary decision to go back and re-experience the calamities of war, a mystery to civilians, who can never understand the intricacies of such a decision. Gil is fighting the war to protect the life and liberty of his family and friends. Other soldiers are not so lucky to have a familial structure back home. Weak familial relationships do not provide an emotional grounding, which can lead to psychological and even physical dangers while overseas. In such cases, with trauma and a lack of attachment back home, soldiers may not see a reason to protect themselves while at war.

After being sexually assaulted, Rebecca did not think of her parents and risked her life when she engaged in warfare unarmed. She decided to unload her gun so she wouldn't kill her attacker, but she never mentions her family until the end of the interview. Other soldiers have major family upsets while at war: spouses die, and girlfriends send “Dear John” letters. Lack of strong familial connections along with disruptions of personal relationships can have detrimental effects on soldiers overseas.

Soldiers commit suicide while they are at war. There are two reasons. One reason is that people can't deal with being in Iraq because they've never been before and they feel like

they have no out except suicide. The other thing is the support groups [families] that are back here at home. Families don't realize how sensitive that subject is. [...] If a wife leaves a husband for someone else because the husband has been away, it can cause many problems for a soldier overseas. It happens a lot to college-aged people. You call back home and she is on a date with someone or a soldier's wife is cheating. It's a big issue for the soldiers. They feel they have no way out except suicide. It takes a strong family support group to keep soldiers going. Each battalion is supposed to have a support group where they talk and communicate and talk about what's happening with the unit. They kind of support each other and see if they need anything. I've known of several people that have committed suicide after getting off the phone with a spouse or girlfriend[...] Anyone can get PTSD from what they've seen at war or from being away from their family. It's a traumatic event for some people, not necessarily that you are killing people and witnessing horrible things, but that you've been with your spouse and you have to go away for a year. That's an event some people can't handle. Even someone like me, who's been married for eight years, it's tough. Tough the first time, tougher the second (John Henry 2010).

Kathleen Vestal Logan developed the "Emotional Cycle of Development Model" for the U.S Naval Institute to describe the soldier-familial separation experience. There are seven stages of development that occur within three main phases: pre-deployment, deployment, and post-deployment (Paton and Meyer, 145). The pre-deployment phase has two stages. The first stage is the "anticipation of loss and separation." Several weeks prior to departure, families experience depression and increased relationship conflict. Spouses may experience shock and numbness after hearing of impending deployment. Immediately prior to deployment, in the second stage, as families plan for separation, there are feelings of anxiety, sadness, anger, frustration, resentment, and guilt. Emotional distancing and suppression is common during this phase. There is a desire to "be close but needing to distance themselves as a defense against the pain of separation (Paton and Meyer 147).

Table 10-1
The Time Frame, Demand Characteristic and Emotional Correlates of Predeployment.

<i>Stage</i>	<i>Title of Stage</i>	<i>Duration of Stage</i>	<i>Characteristics of Stage</i>
Stage 1	Anticipation of loss and separation	Four to six weeks prior to deployment	Denial, crying, irritability, depression, conflict in relationships.
Stage 2	Detachment and withdrawal	Few days prior to deployment	Withdrawal, sexual tension, arguments, despair, hopelessness.

Adapted from Logan (1987) and Pincus et al. (2003)

(Table 10-1 Paton and Meyer).

Table 10-2
The Time Frame, Demand Characteristic and Emotional Correlates of Deployment

<i>Stage</i>	<i>Title of Stage</i>	<i>Duration of Stage</i>	<i>Characteristics of Stage</i>
Stage 3	Emotional disorganisation	First six weeks of deployment	Adjusting, worry, irritability, depression, aimlessness, numbness, sleep disturbance, anger, guilt, relief, disoriented, overwhelmed, security issues.
Stage 4	Recovery and stabilisation	Mid deployment	New routines established, new sources of support, confident and feel more in control, independent, anxious, depressed, illness.
Stage 5	Anticipation of homecoming	Six weeks prior to return	Excitement, joy, apprehension, tension, nervousness, difficulty making decisions.

Adapted from Logan (1987) and Pincus et al. (2003)

(Table 10-2 Paton and Meyer).

The deployment phase is made up of three stages. During the first few weeks after deployment, the family is adjusting to life without their loved one. Problems at home are perceived to increase in frequency and severity. When an adaptation is successful, however, a sense of independence and stability will emerge for the family at home. A failure to adapt increases anxiety, depression, and illness, making deployment hard for the family and the soldier who is unable to help family matters at home. With the anticipation of a soldier returning home, excitement can ensue for reunification, yet this excitement is tempered with apprehension regarding the need for reconciliation of roles and responsibilities (Paton and Meyer 148).

As Gil described in his story, while deployed, partners can experience feelings of worry and guilt over leaving their family. Lack of information about their family or partner, concerns for their safety, loneliness, isolation, and problems coping independently have been implicated as significant family stressors for soldiers overseas. The duration of deployment and uncertainty regarding the duration of deployment is a stressor as soldiers consider their families' new lower standard of living, assumption of new tasks and roles, uncertainty and anxiety regarding their families welfare, and the inability to provide them with emotional support while they are overseas. Soldiers also are concerned about reunion and whether their vision of post-separation life will match reality. A strong familial structure prior to separation is ideal, as it has been found to predict good reunion adjustment in both men and women (Paton and Meyer 153). Partners who are independent and self-sufficient prior to separation usually can cope more easily than those who are not independent. Their families also experience fewer readjustment problems during reintegration. Personnel who had been deployed previously on one or more occasions reported fewer symptoms of stress than their first-time deployed counterparts. This difference is attributed to utilizing previously developed coping mechanisms and personal support systems

that help see them through deployment. Experienced military couples typically learn to make adjustments to service life and have developed a system when a member of the family must be deployed.

Table 10-3
The Time Frame, Demand Characteristic and Emotional Correlates of
Post-deployment/Reintegration.

<i>Stage</i>	<i>Title of Stage</i>	<i>Duration of Stage</i>	<i>Characteristics of Stage</i>
Stage 6	Renegotiation of relationship contract	Six weeks after return	Honeymoon period, loss of independence, need for own space, excitement, emotional distance, sexual difficulties, conflict, re-negotiating roles and routine, reintegration into family.
Stage 7	Reintegration and stabilisation	Six to twelve weeks after return	Over-interpreting arguments, dealing with rumors and re-establishing trust, not accepting changes, re-established/ new roles & routine, marital closeness.

Adapted from Logan (1987) and Pincus et al. (2003).

(Table 10-3Paton and Meyer).

Low levels of support contribute to family stress and vulnerability. As observed among Iraq veterans including Gil and Rebecca, a lack of contact with family back home leads to emotional suppression not just for the soldiers, but also for family members. Family members have to adjust to the uncertainties of the soldier's experiences and adjust during post-deployment familial relations.

The post-development phase is divided into two stages. The first is a loss of independence or structure provided by the military. The family also readjusts in this stage and

soldiers and spouses experience intimacy issues. After this stage, reintegration and stabilization begins as the soldiers reassume their former roles or are positioned in new roles after the acceptance of their spouse's adapted independence since deployment (Paton and Meyer 157).

Stage six is where difficulties arise for families with soldiers that experience PTSD. Rebecca went back home to her family and her family tried to place her back in the role of a child. Rebecca did not want to talk about her attack or her experiences with her family. She tried to conceal her emotions from her family. After dealing with the military and convincing the military psychologist at BAMC that her attack "did" occur, and wasn't just "a fabrication," Rebecca just, "wanted to go home and be left alone." She talks about her experiences today after having received psychological help because, "you have to talk about it because it eats you up and you blame yourself. [...]my mom didn't know til months after she got in an argument with me and I yelled it all out because mom wanted to know why I was so angry. 'There you go!', I said. I tried to kill myself after that; I took a lot of pills that didn't work. I just got sick and had to get my stomach pumped" (Rebecca 2010).

Gil expressed his difficulties with emotional suppression, trying to reintegrate into life back in the States:

It was pretty great coming back. The first feeling was relief, take a nice long forty-five to an hour shower. I had options to think about what I was going to eat. I could take a long shit on a porcelain stall with flushing water, do my own thing and see grass and scenery, whooo! Not have to worry everyday about living or dying. I could see family and friends again, it was pretty great. But, when you came back to America everything was different. It made a huge difference, everyone changed but us. We stayed frozen in time. We came back thinking everything was going to be the same but no, everything evolves and moves on [...]My family and friends just moved on and things weren't the same. Friends had new friends and relationships weren't the same. They [friends] would be intrusive always asking questions and I didn't want to talk about it. I just wanted to forget. It was like they really didn't even care. It was hard to see how many people are so ungrateful about everything and so spoiled, and so ready to misbehave at any given moment. It made me want to backhand the person. I was very frustrated with how people would behave and

how inconsiderate people would be. People taking their freedoms and being careless with it. I never talked to anyone about problems bottled it up because I didn't want anyone to see the weakness. I didn't want to see the weakness in myself because I knew, - I didn't want to document it and have people think I was crazy. When you come back everyone expects you to be kinda crazy and you want to prove them wrong all the more, just kinda like it never happened. Yeah, I still bottle it up, it is easiest that way, some things are better left unsaid" (Gil 2010).

It is difficult for families to try to address and diagnose PTSD. Gil remains undiagnosed yet experiences all the complications that come with PTSD. Rebecca's diagnosis helped her leave the military and she received help at home. Gil acknowledges he can have help but there is reluctance because he fears a loss of benefits if he is diagnosed with PTSD. Rebecca was able to be diagnosed and received a 70 percent disability pension. By speaking out she obtained medical help. It was not easy opening up to her family, but with medical assistance and over the past eight years, she has opened up more. Her friend Ashton recalls Rebecca sharing aspects of her war experience with him.

Talking about war is hard. She went through some hard stuff. Coming back she drank a lot and we partied a lot. We partied a lot. But she went through some tough stuff. She had to shoot at innocent children. When you have to look into a child's face and shoot him that is a traumatic event I could never imagine. We don't talk about it much. She still takes painkillers for her injuries. It use to be real bad, she would drink a lot, now things are better, we don't talk about it much. She still has problems concentrating; she has to take Adderall to focus in school. I'm glad I was her roommate and she opened up to me. We are very close, she still has trouble sometimes thinking about it but she is doing a lot better (Ashton 2010).

In discussing reintegration, Rebecca talks about how her sexual assault helped secure her compensation and benefits,

I'm mentally not as depressed anymore. I have really broken concentration. I did horrible my first year at UTSA. I bombed it. Considering I got into Baylor, and St. Mary's, I would have done worse because those are harder schools. I still deal with concentration problems. I am hating Vista,[community college NW Vista] can't wait to go back to UTSA. The military is paying for everything. It paid rent, and I receive money from being injured for the rest of my life. It's a plus, kind of like their "hush" money. I received a disability of 70 percent, which is really good. People that get shot at don't

even get that. It was really good, they review everything and decide, they get x-rays of my body, if there is something wrong, in every place there is an assigned percentage. A major part of my percentages were from PTSD. I still suffer from it, they acknowledged it on paperwork. If you didn't tell anyone no one would have asked. Sadly they do things like dishonorably discharge people that tell. I was lucky though and they gave me money to keep me quiet about the incident (Rebecca 2010).

Gil refrains from mentioning his illness to secure his spot in the military and to avoid possibility of discharge. During training, he assaulted a drill sergeant after the drill sergeant hit him over the head. By keeping quiet, Gil retained his spot after the drill sergeant's initial assault. Gil's silence about his PTSD diverts unwanted attention from him. Yet living in secrecy and denying PTSD to maintain pride or preserve benefits creates a toxic environment for soldiers and their families. In Eric Dean's analysis of Civil War veterans, *Shook Over Hell* notes, "many of these men continued to suffer from the aftereffects of war and, along with their families, often lived in a private hell involving physical pain, the torment of fear, and the memories of killing and death" (Dean 25).

Discussing re-integration, John Henry states:

Before we go back you get briefings. That you've been gone for ten or twelve months, your family is probably not the same, your kids are a year older, your spouse is acting independently so don't try to come back and take over things. They've been functioning without you for a year. They probably don't do things the same way. They've been handling financial issues without you. It causes a big disruption of family.

There's a very high rate of divorces in military. The one way PTSD shows itself is that the person cannot reintegrate back to the family. He is more angry, he is not more tolerable of things, he can't sleep with someone next to them, they jump or grab you. Spouses report that he wasn't drinking, now he is, wasn't smoking, now is, and the spouse doesn't like it. It causes a lot of issues. The thing about the military is that there are a lot of young soldiers with young kids. You have the rank of an E3 with a lower paying salary, married with two kids and making small amount of money. There's a financial issue, a reintegration issue: now he's back and something's wrong. Unfortunately spouses call the commander and say that, "my husband is beating me." It gets the soldier in trouble. They can take money from your paycheck, which is taking away money from you as a spouse. Or the spouse can stay late and pick up rocks instead of being at home. The spouse gets punished, or they can put the soldier out of the house and into the barracks. The company commander can decide how long it lasts. It is

usually effective. You can be confined to the barracks and only go to work and the hall, and only to the store for necessities, usually with someone escorting you. They can also put you out of the army. They recommend that the soldier was not able to adapt to the Army. The soldier gets a general, honorable, or dishonorable discharge (John Henry 2010).

Coming out and addressing PTSD is much easier today than in previous wars, but there is still a stigma. Benefits can still be denied and soldiers can be discharged from the military if they exhibit a range of activities in trying to cope with their PTSD such as reckless drinking or domestic violence. In November 2003, on the front page of the *Denver Post*, it was reported that Staff Sergeant Georg-Andreas Pogany caught sight of a dead and mangled Iraqi soldier after just two days of active duty. The body was ripped almost in two, with a large hole and strips of flesh where the man's chest should have been. Pogany experienced a panic attack and for four hours could not stop vomiting. He sought help from a chaplain and army psychologist. Both filed reports for him as he was suffering from a common stress response. His commanding officer, however, berated him in front of his fellow Green Berets as a "shit bag," a "fucking coward," with his "head up his ass." Pogany was sent home to face a court-martial for cowardice, a crime still punishable by death. He was displayed in the media as a disgrace to the country. CNN ran footage of Jessica Lynch and Pogany with the subtitle "Heroes and Cowards". In November of 2009, Pogany was hired as Director of Military Outreach and Education by Give an Hour, an organization that provides counseling and treatment to soldiers returning from war (Arrilaga). As of 2005, the VA and State Department still do not keep records of suicides or homicides by veterans, which adds to the perception that PTSD is not such a serious issue. Pogany was vilified and called a "coward" by his own comrades for exhibiting symptoms of PTSD and reaching out for help. Soldiers feel discouraged from acknowledging possible mental issues because of the stigmas attached to them. The soldiers fear that they will be ostracized if they are

viewed as weak or cowardly. The negative associations with PTSD only serve to compound a soldier's problems and decrease the likelihood that he or she will reach out for professional help. Upon returning back from service, families are left to fight to get help and recognition from the federal government for their loved ones' suffering (Coleman 165).

For families who have had to deal with PTSD, taking care of the loved one at home can be difficult and can end in tragedy. Linda Robideau spoke of her husband's suicide. He was a Vietnam veteran.

He came out and he said, "I'm going to do it. I'm sick of this life. I'm sick of the pain. I'm sick of the fucking neighbors. I'm sick of everything. I don't need no doctors or social workers or police. I just want to stop the pain." I got on my hands and knees and I begged him. I said, "Please, please, don't kill yourself, because your pain will be over, but mine will just begin. I can't live without you." So he said, "Okay then, I'll take you with me and then you don't have to worry (Coleman).

Robideau's husband did not shoot her but later killed himself when she was away from home. Relief is a common sentiment shared among many widows of PTSD soldiers as Robideau explains,

There's something else I got to say. It's awful, but when he died, I felt relief. Just for a second. It's the truth. I said, "Oh jeepers, he's finally at peace, he's free from the nightmares and the problems and the pain." I felt so guilty. He held me close for thirteen years. He held me every night. Thirteen years wasn't long enough. I will never forget Don. He's always in my eyes (Coleman 14-15).

Children of PTSD victims also suffer. Paula Evlick talks about her father's suicide,

When my dad died my mother was very ill. I had to pull the funeral together. I went to the VA to ask for help to bury him. I took my father's briefcase full of his commendations and his medals and stuff like that, but when I told them he died from a self-inflicted gunshot wound they said, "The VA won't pay for that." I was so devastated. I had to go to a private funeral home. The day of the burial the VA called me and said they'd made a terrible mistake. They offered to bury him in a military cemetery with a color guard, which is the twenty-one-gun salute and flag and all that. I said it was too late, I'd already paid for the plot. But I took the color guard because I wanted him to have a military funeral. The VA didn't give us anything. They told me that when he killed himself, the pension died with him. It's been a hard thing for me to forgive. My baby brother wasn't even fifteen. I finished my law degree, but then I got suspended. I drank myself out of it

[...] My middle brother, Pete, said he was going to be away and I could have his place in Mendocino while he was gone to work things out. I went home to pack my things and was all ready to come, when I got another five-in-the-morning phone call. Pete had driven his car off a cliff. I didn't see it coming at all. He had a daughter and a son, and loved his kids so much (Coleman 17).

Jean-Marie Fisher talks about her experience with her father's suicide as a child,

I said goodbye to him when he was still on life support. At first, Mom just kept saying it wasn't suicide, it was an accident, and I wasn't allowed to tell anyone. It pissed me off that I wasn't allowed to talk about it. I kept thinking that if it was suicide, we shouldn't have left; we should have stayed there. [...] When he died, at first I handled it in a really bad way. This girl use to bring a water bottle filled with vodka to school, and we would get drunk everyday. I went to classes stoned and I had really bad grades. I thought it should've been me., and so I use to cut myself a lot. [...] lately I've been pretty good. I'm reading a lot of war books. I watched *Full Metal Jacket* and *Platoon*. It makes me see what my dad went through, and I think, wow, no wonder he was weird. And no wonder he was an atheist because a lot of people gave up on God with what they saw. My dad actually killed people. He was trained to kill people. You're trained to kill people, you get shot a lot, and then you come home to a regular family. How weird is that? (Coleman 40-44).

Paula Evlick and Jean-Marie Fisher are examples of how the effects of PTSD expand beyond the servicemen and women. Familial relationships become difficult to maintain when PTSD sufferers cannot cope with the change in family dynamics and their family members cannot cope with the change in the servicemen/women's personality. As a result, family members may choose unhealthy ways to escape, such as alcohol and drug abuse, self-mutilation and suicide. While the presence of a familial support network is significant for a patient with PTSD, the treatment of PTSD requires a much more comprehensive solution, where help from home is coupled with professional medical assistance. Given the extent to which PTSD permeates personal relationships, more attention should be given to research and it should be a higher priority within the Department of Veteran Affairs.

Despite the recognition of PTSD as a psychological disorder in the 1980's, there is still much to be understood and done about PTSD. An alarming number of soldiers returning from

the Afghanistan and Iraq War are diagnosed with PTSD. Unfortunately, U.S. veterans must navigate through the maze of bureaucracy and fight to claim their benefits. It appears that the VA is so concerned with being cheated that it cheats soldiers out of the medical care they have earned. Furthermore, returning soldiers also have to reintegrate back into society and find their place. Families, in many cases, fall apart and soldier suicides are becoming more common. The increasing frequency with which suicides caused by PTSD occur does not necessarily lead to more action from the government. As the wars continue, one can only hope that there will be less apathy and resistance from the government in regard to PTSD, and that veterans will finally receive adequate treatment.

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