

## BOOK REVIEW ESSAY

### **Consequences of Combat: A Review of HAUNTED BY COMBAT: UNDERSTANDING PTSD IN WAR VETERANS INCLUDING WOMEN, RESERVISTS, AND THOSE COMING BACK FROM IRAQ<sup>1</sup> ; and MOVING A NATION TO CARE: POST-TRAUMATIC STRESS DISORDER AND AMERICA'S RETURNING TROOPS<sup>2</sup>**

Holly Seesel, Mary Sorisio, & Paul Sorisio<sup>3</sup>

An April 2008 study of the Rand Corporation found that nearly twenty percent of service members returning from Iraq and Afghanistan have some symptoms of post-traumatic stress disorder (PTSD).<sup>4</sup> Of those returning service members, only half have sought treatment.<sup>5</sup> While PTSD is not a new disability, the current Global War on Terror (GWOT) has brought this disability to the attention of the media and public. Almost every week there is a different news report concerning the recovery and treatment of veterans returning from the Persian Gulf. Given this focus, we have examined two recently published books on the topic: *Haunted by Combat: Understanding PTSD in War Veterans Including Women, Reservists, and Those Coming Back from Iraq* as well as *Moving a Nation to Care: Post-Traumatic Stress Disorder and America's Returning Troops*. While the intended audiences and the themes of the two books are different, both offer insights into understanding the disorder, include suggestions for improving treatment, and identify areas where more research is required.<sup>6</sup> We will examine two topics discussed in each book:

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<sup>1</sup> DARYL S. PAULSON & STANLEY KRIPPNER, HAUNTED BY COMBAT: UNDERSTANDING PTSD IN WAR VETERANS INCLUDING WOMEN, RESERVISTS, AND THOSE COMING BACK FROM IRAQ (2007).

<sup>2</sup> ILONA MEAGHER, MOVING A NATION TO CARE: POST-TRAUMATIC STRESS DISORDER AND AMERICA'S RETURNING TROOPS (2007).

<sup>3</sup> The authors are employed as Associate Counsel with the Board of Veterans' Appeals at the Department of Veterans Affairs.

<sup>4</sup> News Release, *One in Five Iraq and Afghanistan Veterans Suffer from PTSD or Major Depression* (Apr. 17, 2008), <http://rand.org/news/press/2008/04/17/>.

<sup>5</sup> *Id.*

<sup>6</sup> While PTSD is not limited to combat or other military-related stressors, as these books emphasize the experience of veterans with PTSD, those in the military will be the focus of this review.

the changing face of PTSD and treatment options for PTSD. We will then offer suggestions for treatment of PTSD and highlight areas where further research is most needed.

## I. THE CHANGING FACE OF PTSD

In order to keep the illusion of safety in place, Americans have developed a myth of the heroic warrior—“brave in battle and impervious to the psychological damage of warfare.”<sup>7</sup> PTSD challenges this myth because it weakens this heroic vision of soldiers, “leaving society ‘resentful about having its illusions of safety and predictability ruffled by people who remind them of how fragile security can be.’”<sup>8</sup> Both books find that this myth has been affected by the changing face of the military during the GWOT, including military restructuring, training methods, and the increased number of National Guard/Reserve soldiers and female troops. Both books also address the multidimensional etiology of PTSD and how that multidimensional nature has changed the definition of PTSD.

### *The Changing Warrior*

Recent trends in the structure of the military have changed the traditional definition of a warrior. The most significant of these trends includes the increased use of National Guard and Reserve troops; the heightened emphasis on air power supported by special operations troops and lighter, more agile ground forces; different training techniques; and the blurring of traditional gender roles.

In 2007, National Guard and Reserve troops comprised forty percent of the frontline forces in Iraq and over fifty percent of those stationed in Afghanistan.<sup>9</sup> Paulson and Krippner discuss the experiences of these veterans in comparison to Vietnam veterans, the overwhelming majority of whom were assigned from active duty units, and the implications of such differences on the development of PTSD.<sup>10</sup> Paulson

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<sup>7</sup> MEAGHER, *supra* note 2, at 46.

<sup>8</sup> *Id.* (quoting TRAUMATIC STRESS: THE EFFECTS OF OVERWHELMING EXPERIENCE ON MIND, BODY, AND SOCIETY 27 (Bessel A. van der Kolk et al. eds., 1996)).

<sup>9</sup> *Id.* at 95.

<sup>10</sup> PAULSON & KRIPPNER, *supra* note 1, at 35.

and Krippner identify stressors leading to the development of PTSD that are unique to the National Guard and Reserve veterans, including a greater length of time leading up to deployment and eventual combat and a greater attachment to the unit with which they served, as compared to Vietnam veterans. Vietnam veterans required two to four weeks of advanced combat training prior to departing for Vietnam.<sup>11</sup> In contrast, GWOT reservists require four to eight weeks of training before they are at an active duty level. They then undergo additional training and simulation in an environment akin to Iraq prior to leaving for active duty. Thus, a one-year tour of duty in actuality becomes one-and-a-half years away from their families, placing a lot of strain on service members and their families.<sup>12</sup> This greater length of time leading up to deployment and eventual combat is significant in that studies have found that stress is highest before a battle begins, drops during actual fighting, and rises again after there is time to reflect upon events that have occurred.<sup>13</sup>

The attachment of Iraq veterans to the units with which they served has also had implications in the development of PTSD.<sup>14</sup> Iraq veterans went to Iraq with their units, returned from battle together, and were then debriefed at a United States base together before they returned home.<sup>15</sup> They strongly identify with their units;<sup>16</sup> thus, they have a built-in support system and are less likely to view their wartime participation as a negative experience. Vietnam veterans, on the other hand, complained of a lack of shared spirit.<sup>17</sup> Other than at the beginning of the Vietnam War, soldiers were sent into Vietnam as replacement soldiers and underwent hazing by their units; hence, these soldiers never developed as much loyalty to the members of their units.<sup>18</sup> When they were released, they were “let out in the street” within hours of their homecoming.<sup>19</sup>

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<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 36.

<sup>14</sup> *Id.* at 37-38.

<sup>15</sup> *Id.* at 44.

<sup>16</sup> *Id.* at 38.

<sup>17</sup> *Id.* at 44.

<sup>18</sup> *Id.* at 38, 44.

<sup>19</sup> *Id.* at 44.

Paulson and Krippner believe the collective group identity in the Iraq war has been both a blessing and a curse. Most notably, they state that it was easier for Vietnam veterans to form new or renewed relationships with their friends and families upon returning home because they did not have the continued unit relationship Iraq veterans had.<sup>20</sup> In contrast, Iraq veterans reported needing time away from their friends and families upon returning home.<sup>21</sup> Additionally, Iraq war veterans have been unable to find value in their own personal belief systems because they are still tied to the collective unit; hence, they are unable to integrate their own view into this collective one.<sup>22</sup>

Meagher also identifies significant differences experienced by active duty troops and National Guard and Reserve troops that impact the potential for development of PTSD, including that National Guard and Reserve troops often lack the transport and non-medical support network of the regular forces to help “navigate the ravel of combat deployment.”<sup>23</sup>

While not limited to National Guard and Reserve troops, Meagher also discusses changes in combat strategy since the war in Vietnam that have led to three new types of combat strain.<sup>24</sup> The first is “time strain” that results from continuous operations with little or no time to relax and unwind.<sup>25</sup> The second is “space strain” because of the lack of traditional frontlines, which do not allow troops adequate breaks from combat.<sup>26</sup> The third is “target strain,” which develops because of the guerilla conditions of today’s warfare that make it difficult to distinguish enemy from civilian.<sup>27</sup> In this regard, she notes that today’s military service members in the Persian Gulf listen to the frustrations of the civilians, but they do not have the tools to help these civilians.<sup>28</sup> Paulson and Krippner also discuss the

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<sup>20</sup> See *id.* at 46.

<sup>21</sup> *Id.* at 44-45.

<sup>22</sup> *Id.* at 55.

<sup>23</sup> MEAGHER, *supra* note 2, at 95.

<sup>24</sup> *Id.* at 90.

<sup>25</sup> *Id.* (explaining that night vision and around-the-clock operations resulted in troops rarely getting the proper rest, leading to fatigue and sleep deprivation).

<sup>26</sup> *Id.* at 91 (noting that space strains could also be exacerbated further by lack of electricity and bathing).

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

stresses related to new methods of warfare. For instance, nearly every Iraq veteran they interviewed had a firsthand experience with improvised explosive devices (IEDs) being detonated near their vehicles.<sup>29</sup> This threat led to a near constant anxiety when driving the roads of Iraq.<sup>30</sup>

The heightened emphasis on air power supported by special operations troops and lighter, more agile ground forces has also impacted the development of PTSD in GWOT veterans. Meagher, in this regard, discusses the effect of the “Rumsfeld Revolution” on the military during the GWOT. Former Secretary of Defense Donald Rumsfeld instituted a massive restructuring of the military using an approach that placed less emphasis on large, mechanized formations and greater emphasis on air power supported by special operations troops and lighter, more agile ground forces.<sup>31</sup> Meagher suggests that this altered emphasis resulted in the neglect of troops. In restructuring the military in this fashion, she finds that Rumsfeld neglected his responsibility as Secretary of Defense to properly protect and supply the troops in his care and by failing “to prepare for, or react to, the unwanted outcomes and unexpected setbacks of warfare.”<sup>32</sup> She notes that the military is obligated to provide three supports to its soldiers: (1) in-depth and realistic training in what soldiers will face in battle and the proper tools to do their job; (2) unit community and stability (cohesion); and (3) capable, moral, and reinforced leadership.<sup>33</sup> As examples of these neglected responsibilities of the military, Meagher cites providing inadequate body armor, utilizing extended and multiple deployments, using National Guard and Reserve forces as fully activated combat troops, and ignoring advice concerning adequate troop levels.<sup>34</sup> Meagher concludes that each of these failures has had a detrimental effect on the physical and psychological well-being of the service members.<sup>35</sup>

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<sup>29</sup> PAULSON & KRIPPNER, *supra* note 1, at 36.

<sup>30</sup> *Id.* at 37.

<sup>31</sup> MEAGHER, *supra* note 2, at 71-72.

<sup>32</sup> *Id.* at 72.

<sup>33</sup> *Id.* at 75 (citing to Jonathan Shay, a noted author and psychiatrist at the Department of Veterans Affairs).

<sup>34</sup> *Id.* at 74-75.

<sup>35</sup> *Id.* at 75.

With regard to training, Meagher finds that the training techniques used today “turn our fighting men and women into Rambo-like killing machines.”<sup>36</sup> In order to survive combat, recruits must overcome “the universal human phobia”—the aversion the majority of persons have to committing aggressive acts against others.<sup>37</sup> In this regard, the American military uses sophisticated techniques to assist recruits in unlocking the psychological safeties that most humans have in place against the use of lethal force.<sup>38</sup> While these techniques are effective in creating professional soldiers whose job is to kill the enemy, they are ineffective in stopping the long-term psychological harm that comes with such killing.<sup>39</sup> Meagher notes that there is little concern for how such training will affect the trainees once they return from combat.<sup>40</sup> As a possible mitigating factor, she notes that a former West Point instructor has suggested that to limit feelings of guilt, troops should be taught from basic training that they “have a justified reason for killing during wartime: self-defense.”<sup>41</sup>

Finally, the increased number of women in the military has resulted in a restructuring of the military and a breakdown of the heroic warrior myth as a result of the blurring of traditional gender roles.<sup>42</sup> In recent years, traditional male and female roles have become transmuted as males and females have stepped into each other’s stereotypical roles.<sup>43</sup> Forty-one thousand women have served in the Gulf War in general combat support roles.<sup>44</sup> Currently, fifteen percent of active duty troops and twenty-five percent of reservists are women;<sup>45</sup> by 2007, about 160,000 female soldiers were serving in Iraq, many of whom had been killed, wounded, or

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<sup>36</sup> *Id.* at 83.

<sup>37</sup> *See id.* at 84 (citing DAVE GROSSMAN, ON KILLING: THE PSYCHOLOGICAL COST OF LEARNING TO KILL IN WAR AND SOCIETY 4 (1995)).

<sup>38</sup> *Id.* at 85 (identifying techniques like conducting killing exercises in realistic environments through the use of virtual reality, practicing firing a gun until it becomes a reflexive action, and conditioning soldiers to “hyper-bond” with their M-16 rifles).

<sup>39</sup> *Id.* at 85-86.

<sup>40</sup> *Id.* at 84.

<sup>41</sup> *Id.* at 86 (noting that these views were espoused by former West Point philosophy instructor, Army Major Peter Kilner).

<sup>42</sup> PAULSON & KRIPPNER, *supra* note 1, at 16.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> Amy Cox, *Women at War: Mental Health Toll Unknown* (May 22, 2007), <http://www.cnn.com/2006/US/05/26/ch.women.vets/index.html> (originally published in May 2006).

diagnosed with PTSD or other psychological disorders.<sup>46</sup> In comparison, there were only 7,500 female soldiers in Vietnam, a much smaller percentage.<sup>47</sup>

The increased percentage of women in the military has had an effect on the number of veterans diagnosed with PTSD. Studies show that PTSD is twice as common in women as among men.<sup>48</sup> There has not been evidence that women are less able to cope with stressors of combat; rather, studies suggest that the more intense the combat, the greater the impact is on males in comparison with females.<sup>49</sup> Possible explanations for the higher incidence of PTSD in women could include the fact that women are more willing to seek treatment than are men,<sup>50</sup> and women are faced with additional stressors that are less common among men, such as rape, sexual harassment and assault, leaving their children at home, and trying to defy stereotypes.<sup>51</sup>

### *The Changing Definition of PTSD*

PTSD has afflicted soldiers since the first war was fought and has been known by many different names throughout the centuries. A Swiss physician first called the disorder *nostalgia* in 1678 after Swiss soldiers had adverse reactions to combat.<sup>52</sup> During the Civil War era, new terms of *irritable heart* and *soldier's heart*<sup>53</sup> emerged as the incidence of combat-

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<sup>46</sup> PAULSON & KRIPPNER, *supra* note 1, at 17 (noting that at the end of 2006, seventy females “had been killed in Iraq, more than the total from the Korean, Vietnam, and Gulf wars combined”).

<sup>47</sup> *Id.* at 138.

<sup>48</sup> *Id.* at 10; MEAGHER, *supra* note 2, at 92.

<sup>49</sup> PAULSON & KRIPPNER, *supra* note 1, at 17.

<sup>50</sup> *Id.* at 10.

<sup>51</sup> *Id.* at 138.

<sup>52</sup> MEAGHER, *supra* note 2, at 13-14 (indicating that symptoms of *nostalgia* included disturbed sleep, constant thoughts of home, anxiety, weakness, heart palpitations, fever, and loss of appetite).

<sup>53</sup> PAULSON & KRIPPNER, *supra* note 1, at 9; MEAGHER, *supra* note 2, at 15 (describing the main symptoms of *irritable heart* as hyperarousal, anxiety, and hyperventilation).

related psychological trauma rose significantly.<sup>54</sup> Then, as a result of the more vicious and modern types of warfare used in World War I (WWI), the terms *shell shock* and *combat neurosis* were coined for the fact that soldiers acted as though they had sustained a shock to their system.<sup>55</sup> Many soldiers suffering from this condition became deaf, blind, or paralyzed, even though they did not suffer any physical injuries.<sup>56</sup> During the World War II (WWII) era, the terms used to describe psychological symptoms resulting from combat experiences included *battle fatigue* and *operational fatigue*.<sup>57</sup>

The clinical definition of PTSD has also evolved over the years. In 1950, the first edition of the *Diagnostic and Statistic Manual of Mental Health Disorders* (DSM) included a definition for combat stress and indicated that “gross stress reactions” originated from catastrophic events or combat.<sup>58</sup> During the Vietnam War, however, all reference to combat stress was removed from the DSM. It was not until the third edition of the DSM was issued in 1980 that the term post-traumatic stress disorder came into being and a comprehensive definition for the disability was created.<sup>59</sup> The current definition of PTSD is set forth in the fourth edition of the DSM.<sup>60</sup> PTSD is now known to be triggered by traumatic events, such as combat, accidents, natural disasters, sexual assault, rape, torture, or abuse

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<sup>54</sup> MEAGHER, *supra* note 2, at 14. Soldiers with psychological reactions to combat traumas were labeled “cowards” or “malingerers” and desertion became a common phenomenon during the Civil War. *Id.*

<sup>55</sup> PAULSON & KRIPPNER, *supra* note 1, at 9.

<sup>56</sup> MEAGHER, *supra* note 2, at 16.

<sup>57</sup> PAULSON & KRIPPNER, *supra* note 1, at 9. Important lessons learned during WWII included that it was more likely that inexperienced troops would suffer from combat stress than seasoned soldiers, that more intense combat increased the likelihood of a stressful reaction, and that group morale was a huge factor in preventing war trauma. MEAGHER, *supra* note 2, at 18.

<sup>58</sup> MEAGHER, *supra* note 2, at 20.

<sup>59</sup> *Id.*

<sup>60</sup> AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 463 (4th ed., text rev., 2000) (defining the “essential feature” of PTSD as “the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person’s response to the event



and is exemplified by changes in behavior, attitude, or values.<sup>61</sup> Common symptoms of PTSD include flashbacks, hypervigilance, anxiety, sleep disturbance, impaired impulse control, suicidal ideations, guilt, depression, panic attacks, and substance abuse.<sup>62</sup>

Paulson and Krippner posit that while the name and clinical definition for PTSD have changed over the years, the current definition of PTSD is too simplistic and is applied too liberally. Studies show that one in four individuals exposed to traumatic threats, to include war, develop PTSD.<sup>63</sup> In fact, Paulson and Krippner argue that PTSD is a spectrum, or continuum, that could include between thirty to ninety percent of all veterans, depending on the diagnostic criteria used.<sup>64</sup> Thus, in defining this continuum, Paulson and Krippner would have the low end consist of those people who exhibit symptoms with an event not generally considered traumatic.<sup>65</sup>

Whereas PTSD was once thought to originate only from the traumas of battle, current research shows that the etiology of PTSD is multidimensional, with the media and popular sentiment playing a role in its development. By way of example, Paulson and Krippner note that during WWII, the citizens and media of the United States supported the troops and trumpeted every military success.<sup>66</sup> On the other hand, the media portrayed the Vietnam and Korean Wars darkly.<sup>67</sup>

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must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).”)

<sup>61</sup> PAULSON & KRIPPNER, *supra* note 1, at 2.

<sup>62</sup> *Id.* at 15.

<sup>63</sup> *Id.* at 13-14 (explaining that a 2005 study of the United States National Center for PTSD reported that thirty percent of combat veterans had PTSD at some point, which most explain is a consequence of killing another human being).

<sup>64</sup> *Id.* at 9.

<sup>65</sup> *Id.* at 10.

<sup>66</sup> *Id.* at 12.

<sup>67</sup> *Id.*

Furthermore, there was a lack of public support for these wars, and veterans returned home to taunts, to include being called “babykillers” and “warmongers.”<sup>68</sup> The depiction of the current war in Iraq and Afghanistan is colored by the fact that the media is now embedded with troops and reports directly from the front line.<sup>69</sup> In other words, the current portrayal of the war shows what the troops endure but may also counter the official government party line.<sup>70</sup> Thus, for current veterans, the onset of PTSD can be hastened, delayed, or directed depending upon the news report one views.<sup>71</sup>

Meagher cites a 2004 Pew Research Poll that found that eighty-two percent of Americans consume some sort of news on an average day. She emphasizes, however, that the type of news Americans seek, along with the quality and content of the news they eventually find, leave many misinformed.<sup>72</sup> For example, Meagher blames the media’s failure to accurately inform the American public in the run-up to the invasion of Iraq and society’s fear at facing the truth about the horrors of war as the reason a large percentage of Americans believed that the invasion of Iraq was in retaliation for Saddam Hussein’s role in the attacks of September 11, 2001.<sup>73</sup> Meagher reviews more problems with the media including the failure to ask enough of the right questions, the denial of access to top government sources, reporters being labeled as unpatriotic if they ask unpopular questions, and limits on the variety of available news sources.<sup>74</sup> The author also blames censorship.<sup>75</sup> She places blame on the government’s ban of the media showing flag-draped coffins and on the

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<sup>68</sup> *Id.* at 19.

<sup>69</sup> *Id.* at 12.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> MEAGHER, *supra* note 2, at 40 (noting that the Pew poll revealed that only thirty-one percent consistently follow international news while thirteen percent stay away from it altogether).

<sup>73</sup> *Id.* at 40-41 (explaining that one poll showed that “50 percent [of people surveyed] also believed that ‘one or more of the September 11 hijackers were Iraqi citizens’ when none in fact were” (quoting Martin Merzer, *Americans Are Against Unilateral War in Iraq*, KNIGHT RIDDER NEWS SERVICE, Jan. 15, 2003)).

<sup>74</sup> *Id.* at 42-43 (discussing also how many news organizations admitted to “dropping the ball” concerning their pre-war reporting).

<sup>75</sup> *Id.* at 44 (citing examples of censorship, including when some stations refused to air the show *Nightline* because Ted Koppel was going to read the names of troops that had been killed).

escapist attitude of the American public, which she illustrates by noting that there were a greater number of votes cast in 2006 for the *American Idol* winner than were cast for President Bush in the 2004 presidential election.<sup>76</sup> She discusses that until early 2006, most guests appearing on popular political news shows were generals, political pundits, and government officials in favor of the war; it is only recently that returned combat veterans and veterans service representatives have been appearing to raise awareness regarding the stories of combat veterans.<sup>77</sup> Meagher believes that these factors combined show a lack of support for veterans afflicted with PTSD, worsening their plight. Meagher notes that for real change, society must be ready to accept the realities of war, listen to veterans' stories, and "no longer hide behind the myths" society has created, stressing that "we can embrace the real stories of our American heroes."<sup>78</sup>

Paulson and Krippner also discuss the influence of popular sentiment on whether one will develop PTSD. The authors note that current popular sentiment is paradoxical, as citizens support the troops but generally do not support the war.<sup>79</sup> Apathy and estrangement are furthered by the inability of civilians to identify with veterans and the belief that the soldiers should have expected what they encountered when they volunteered.<sup>80</sup> As many civilians are not affected personally by the war, there is a lack of any passionate impetus for involvement with the war.<sup>81</sup> Thus, the returning veteran sees no positive meaning for his involvement in Iraq.<sup>82</sup> The unpopularity of the war also results in increased avoidance symptoms as veterans try to distance themselves from involvement in the war as they battle existential conflicts, feelings of shame, alienation, homelessness, and unemployment.<sup>83</sup> Even if the returning veterans initially felt that they were heroes, the unpopularity of the war may drive them to hide experiences and feel unworthy of love.<sup>84</sup> The added difficulty of losing the sense of one's self, as prior to discharge the veteran was part

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<sup>76</sup> *Id.* at 45.

<sup>77</sup> *Id.* at 48.

<sup>78</sup> *Id.*

<sup>79</sup> PAULSON & KRIPPNER, *supra* note 1, at 20.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 20, 37.

<sup>83</sup> *Id.* at 20-21.

<sup>84</sup> *Id.* at 28.

of the military and after discharge is no longer part of an organized group, results in low-level anxiety, which can cause dangerous behavior.<sup>85</sup>

Just as pre-trauma factors influence whether one develops PTSD, the post-traumatic environment can also hasten or delay the development of the disability. For example, Paulson and Krippner indicate that incidents later in life summoning traumatic memories will reinforce and aggravate classic PTSD.<sup>86</sup> They caution that in investigating PTSD and treating veterans, one must remember that military action and combat do not occur in a vacuum but rather occur in a web of complicated cultural interactions including the political climate at home, cultural attitudes of the host country's government, and attitudes of the larger international world.<sup>87</sup>

## II. TREATMENT OPTIONS FOR PTSD

Paulson and Krippner explain that PTSD is difficult to treat because of the multidimensional nature of its etiology. PTSD is not a simple disorder that is easily diagnosed but rather is a complex response to protect oneself from a systematic or prolonged threat.<sup>88</sup> The lives of those exposed to combat change, resulting in stalled long-term plans and decreased joy in life.<sup>89</sup> Veterans become vigilant when there is no actual threat; many explain that while they first think they are overreacting they later believe there is a threat looming somewhere.<sup>90</sup> This protection strategy against nonexistent threats results in further anxiety and becomes a vicious cycle.<sup>91</sup>

Over the years, the military has revised its treatment options for PTSD. Meagher, Paulson, and Krippner offer some praise for the military's revised treatment options; however, they argue that even these new treatments fail to truly address the underlying problem and as such fail to prevent or effectively treat PTSD. Similarly, while there are several treatment options available, the authors argue that these treatment options are unsuccessful in treating PTSD in combat veterans.

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<sup>85</sup> *Id.* at 30.

<sup>86</sup> *Id.* at 14.

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 26.

<sup>89</sup> *Id.* at 27.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

## *Development of Current Military Treatment Methods*

One of the ways the military has attempted to prevent and treat PTSD is by providing counseling throughout a soldier's deployment.<sup>92</sup> The first comprehensive treatment program for psychiatric disabilities was created for active duty service members during WWI.<sup>93</sup> That program placed psychiatrists in combat units and centered around four key ideas of treatment: (1) treating the soldier in close proximity to the battle; (2) treating the soldier as immediately as possible; (3) providing simple treatment, such as rest, a warm shower, and food; and (4) having the expectation that the soldier would be able to return to fight after treatment.<sup>94</sup> These ideas remain the cornerstone for treating combat stress during military service. While advances were made during WWI, beliefs were still held that the pre-enlistment screening for psychological problems was an effective way to minimize combat trauma cases and only men of weaker character succumbed to stress from combat.<sup>95</sup>

At the beginning of WWII, pre-enlistment screening was thought to be such an effective tool that the innovative program of treating mental trauma on the battlefield was halted.<sup>96</sup> As a result, psychological casualties were 2.4 times higher than in WWI.<sup>97</sup> The pre-screening initiative was a complete failure, and more soldiers were being kept out of the military than were being allowed to join.<sup>98</sup> Important lessons learned during WWII included that it was more likely that inexperienced troops would suffer from combat stress than seasoned soldiers, that more intense combat increased the likelihood of a stressful reaction, and that group morale was a huge factor in preventing war trauma.<sup>99</sup> During the Korean War, the program of treating troops for combat stress in the field was reinstated and new treatment methods, including a rotation system to allow for periods of rest and relaxation, were incorporated.<sup>100</sup> In the initial stages of the Iraq

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<sup>92</sup> *Id.* at 21.

<sup>93</sup> MEAGHER, *supra* note 2, at 16.

<sup>94</sup> *Id.* at 16-17.

<sup>95</sup> *Id.* at 17.

<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> *Id.* at 17-18.

<sup>99</sup> *Id.* at 18.

<sup>100</sup> *Id.*

War, all previously used methods of forward treatment on the battlefield were disregarded, with the consequence of an increase in murders and suicides committed by soldiers and returning veterans.<sup>101</sup>

In 2004, the Army and Marines learned from these mistakes and launched programs that placed mental health professionals in combat zones.<sup>102</sup> Similar to programs used during WWI, the main goal is to return troops to duty efficiently and to do so as close to their unit as possible to prevent development of the condition.<sup>103</sup> It is once again being understood that early intervention is key to preventing combat stress from turning into chronic PTSD.<sup>104</sup> The Army's Combat Stress Control program has goals of brevity, immediacy, centrality, avoiding stigmatization, proximity, expectancy, and simplicity.<sup>105</sup> Paulson and Krippner, however, criticize these programs as they provide limited treatment that relies heavily on pharmaceuticals.<sup>106</sup>

Meagher also argues that onsite treatment is ineffective because the military uses a "wall of resistance" when troops seek to obtain help for combat stress.<sup>107</sup> As an example she cites a threat made by a superior to make a private's life "a living hell" if he got a medical discharge for PTSD.<sup>108</sup> In addition, efforts are made to portray troops as "psychologically impaired *before* they went to war, morally weak, or untruthful, malingering veterans."<sup>109</sup> As a result of this "wall of resistance," many troops self-medicate with drugs and alcohol to treat their PTSD, leading to them either being threatened with or given other than honorable discharges.<sup>110</sup>

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<sup>101</sup> *Id.* at 21.

<sup>102</sup> *Id.*; PAULSON & KRIPPNER, *supra* note 1, at 21.

<sup>103</sup> PAULSON & KRIPPNER, *supra* note 1, at 21.

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> *Id.* at 21-22.

<sup>107</sup> MEAGHER, *supra* note 2, at 66.

<sup>108</sup> *Id.* at 65.

<sup>109</sup> *Id.* at 65-66 (quoting D.E. FORD, ET AL., BLAMING THE VETERAN: THE POLITICS OF POST TRAUMATIC STRESS DISORDER, [http://www.epluribusmedia.org/features/20060206PTSD\\_intro.html](http://www.epluribusmedia.org/features/20060206PTSD_intro.html) (last visited Oct. 27, 2008)).

<sup>110</sup> *Id.* at 66-69 (noting that forty other than honorable discharges were given for marijuana use in one particular unit).

The military has also attempted to identify and treat PTSD by requiring all veterans to undergo a post-deployment health assessment during the demobilization process.<sup>111</sup> The process of demobilization has changed greatly over the years resulting in the loss of decompression time, which may result in ineffective identification of PTSD in troops who have returned so quickly from a combat zone.

Paulson and Krippner note that Iraq veterans undergo one to two weeks of demobilization from being on active duty to reserve duty.<sup>112</sup> During this time, they can request to undergo counseling, although the authors contend that this counseling program has probably not been very effective because of the delay between a traumatic event and the appearance of symptoms of PTSD.<sup>113</sup>

Meagher additionally examines how the speed of moving troops from a combat zone to the home front has become extremely quick over the years, in her opinion increasing the likelihood of the development of PTSD. She notes that the development of air travel has eliminated the “built-in purification rituals” available to earlier troops.<sup>114</sup> Years ago, returning from war meant plodding along by horse, train, or ship, leaving returning troops time to deal with what they had experienced in a safe and quarantined environment instead of being thrown back into society without a chance to decompress and process their wartime experiences.<sup>115</sup> Meagher also attributes today’s mental health problems to the lack of healing and cleansing rituals in contemporary western society.<sup>116</sup> She states that society must engage in cleansing rituals to show approval for the wartime deeds of our soldiers but fails to point out any such rituals other than the fleeting effects of a “Welcome Home” parade.<sup>117</sup> Meagher further discusses the problem of veterans and homelessness, especially among those with PTSD.<sup>118</sup> She notes that John Driscoll, the communications director of

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<sup>111</sup> *Id.* at 28; see Emily Keram, *PTSD in Afghanistan and Iraq War Veterans*, 57 SONOMA MED., Summer 2006, available at <http://www.sonic.net/~scma/magazine/scp/sm06/keram.html>.

<sup>112</sup> PAULSON & KRIPPNER, *supra* note 1, at 44.

<sup>113</sup> *Id.*

<sup>114</sup> MEAGHER, *supra* note 2, at 121.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.* at 122-23.

<sup>117</sup> *Id.* at 123.

<sup>118</sup> *Id.* at 124.

the National Coalition for Homeless Veterans, has stated that “the key to a successful transition out of military life is a large support network of family, friends, and service providers.”<sup>119</sup>

Another recent initiative of the military has been to offer marriage programs to veterans and their families, such as “marriage enrichment” sessions and “romantic getaways.”<sup>120</sup> These programs were implemented in an effort to promote sturdier relationships and to reduce the divorce rate among veterans.<sup>121</sup> Paulson and Krippner criticize the use of a family system approach of therapy. This type of therapy recognizes that trauma strains the entire family and aims at restructuring the roles and rules of the family to cope with the trauma. However, this type of therapy is difficult to manage, as family members may be unavailable or unwilling to participate, it requires lengthy treatment, and a facilitator will often discover that the war trauma is interwoven with preexisting dysfunctionality that is resistant to change.<sup>122</sup>

### *Effectiveness of Current Psychotherapy Treatment*

While Meagher does not emphasize the treatment of PTSD, Paulson and Krippner discuss currently available treatment options in detail. They indicate that many assume that the VA or military will fix those who have PTSD but note that this requires considerable individual and group therapy, which is expensive and time consuming.<sup>123</sup> Many veterans shy away from discussing the traumatic events and as such the techniques that rely on this method will take time and a highly motivated client to deal with the trauma.<sup>124</sup>

Additionally, Paulson and Krippner argue that many current forms of treatment require veterans that are hesitant to discuss their memories to pry deeply into memory. This detailed prying into memory used in the developmental approach of psychology may have the effect

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<sup>119</sup> *Id.*

<sup>120</sup> PAULSON & KRIPPNER, *supra* note 1, at 16.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 73-74.

<sup>123</sup> *Id.* at 21.

<sup>124</sup> *Id.*



of re-traumatizing the veteran or alternatively turning him into a “trauma junky.”<sup>125</sup> While Paulson and Krippner encourage any type of therapy, they also criticize many of the currently available treatments in part for relying too heavily on medication and for allowing cost concerns to eliminate the expensive and time-consuming individual and group therapy generally required by traumatic wounds.<sup>126</sup>

Paulson and Krippner advocate a current method of treatment for returning veterans that focuses on psychotherapy rather than the current and past focus on medication.<sup>127</sup> The authors recognize that medication is a cheaper option but find that it is not the most effective way to deal with the problems that underlie a PTSD diagnosis.<sup>128</sup>

Veterans need to realize that when they return from combat, their environment will have changed and that they will not be able to return to life as if nothing had happened.<sup>129</sup> In accordance with this, Paulson and Krippner find that “the most damaging effect of war trauma is the loss of the empowering personal myths . . . .”<sup>130</sup> The “individual perspective or personal myth . . . ensures the security and safety of the world.”<sup>131</sup> Complications arise from the effects of rule-governed behavior, or the practice of defining and judging actions from life rules or personal myths.<sup>132</sup> For example, the veteran dismisses feelings of anxiety at home after returning from combat as “bad” or “stupid.”<sup>133</sup> This behavior suppresses symptoms, “further obscuring the root of the problem and complicating treatment.”<sup>134</sup> The loss of this perspective is not easy to treat, and the authors are quick to indicate that treatment through usual drugs, catharsis, deconditioning, and social support help only to the extent that they replace the myths and/or revitalize meaning.<sup>135</sup>

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<sup>125</sup> *Id.*

<sup>126</sup> *Id.* at 22.

<sup>127</sup> *Id.* at 51-53.

<sup>128</sup> *Id.* at 51.

<sup>129</sup> *Id.* at 58.

<sup>130</sup> *Id.* at 81 (explaining that losing the myth makes finding positive meaning a challenge).

<sup>131</sup> *Id.* at 4.

<sup>132</sup> *Id.* at 3-4.

<sup>133</sup> *Id.* at 4.

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

Another therapy approach discussed by Paulson and Krippner is the cognitive behavioral approach.<sup>136</sup> “Through a variety of procedures, [patients] are . . . taught how to modify or abandon illogical ideas and self-defeating activities.”<sup>137</sup> This type of therapy, they state, is particularly helpful in assisting the veteran to move on and remove himself from toxic environments.<sup>138</sup> The authors caution, however, that this type of treatment requires considerable time and is not appropriate for everyone. For example, physical changes, such as moving, getting divorced, or changing jobs, will be ineffective if the client does not address the behaviors and attitudes that existed and made the old physical environment toxic.<sup>140</sup>

Paulson and Krippner also examine the use of alternative treatment and therapy, including religion, holistic medicine, and yoga. For example, they describe Chinese treatments for the loss of “chi” energy through “acupuncture, diet, massage, and herbs, including burning ‘moxa’ on . . . the body’s ‘energy centers.’”<sup>141</sup> They also refer to the new practices known as energy psychology,<sup>142</sup> which stimulates the “energy centers” in order to change one’s thoughts and actions; traumatic incident reduction,<sup>143</sup> which seeks to get at the root of the problem by uncovering repressed memories; and eye movement desensitization and reprocessing,<sup>144</sup> which requests the client focus on certain aspects of the distressing experience to desensitize the client. Another new treatment is virtual reality treatment where the patient is given goggles and headphones to place him or her in a different setting, which resembles a video game and therefore lessens the stigma of psychotherapy.<sup>145</sup>

The authors also discuss an emerging treatment involving the development of drugs to eliminate traumatic events from memories, preferably to be administered directly after combat trauma before the

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<sup>136</sup> *Id.* at 75-77.

<sup>137</sup> *Id.* at 76.

<sup>138</sup> *Id.* at 75-77.

<sup>139</sup> *Id.* at 75.

<sup>140</sup> *Id.* at 76.

<sup>141</sup> *Id.* at 122.

<sup>142</sup> *Id.*

<sup>143</sup> *Id.* at 123.

<sup>144</sup> *Id.* at 124.

<sup>145</sup> *Id.* at 132.

memories become long-term memories.<sup>146</sup> While some psychotherapists criticize this technique as too impersonal, the authors note the treatment takes place within a psychotherapeutic context and, given the high number of people with trauma, daring procedures are needed.<sup>147</sup>

Regardless of the treatment approach, Paulson and Krippner indicate that Paulson's work with combat veterans and war victims revealed that it was crucial that "the client must be heard truly and be taken seriously by the therapist."<sup>148</sup> The victim needed to tell the story, including all feelings such as pain, rage, despair, guilt and hatred.<sup>149</sup> Paulson and Krippner state that veterans need to be proactive in seeking treatment and need to recognize that they are not victims but instead are people who have the power to determine the path their lives will take.<sup>150</sup>

Paulson and Krippner recommend a three-stage method that therapists can employ in uncovering a veteran's experiences that they refer to as their "personal myths": (1) the call to adventure; the event or motivation that made the veteran decide to join the military;<sup>151</sup> (2) the initiation, the combat experiences the veteran had and how this changed his or her values and beliefs;<sup>152</sup> and (3) the return, the period usually requiring psychotherapy, when the veteran discovers the value he or she can derive from his or her wartime experiences.<sup>153</sup> This last stage marks the end of the wartime experience and the beginning of a new experience where he or she can take his or her newfound values and apply them to improve their lives.<sup>154</sup>

Paulson and Krippner warn that during early stages of therapy such a view is contraindicated by the anxiety, depression, and feelings of loss.<sup>155</sup> After the client deals with the trauma and is somewhat desensitized

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<sup>146</sup> *Id.* at 132-33.

<sup>147</sup> *Id.* at 133.

<sup>148</sup> *Id.* at 84.

<sup>149</sup> *Id.*

<sup>150</sup> *Id.* at 52-53 (noting estimates that one out of six returning veterans requires some type of psychotherapeutic care, not just those veterans suffering from PTSD).

<sup>151</sup> *Id.* at 56-57.

<sup>152</sup> *Id.* at 57.

<sup>153</sup> *Id.* at 57-58.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.* at 84.

to it, however, the mythic rite of passage will become beneficial in healing the veteran.<sup>156</sup>

Regardless of how bad their experiences were, veterans have the opportunity to transcend them and to engage in positive growth.<sup>157</sup> Paulson and Krippner believe that each veteran can discover, within themselves, a distinctive character trait that they gained from their combat experience and that they can then incorporate that “post-traumatic strength” into their lives.<sup>158</sup> The authors view a “post-traumatic strength” as each veteran’s individual reward for what they experienced during their military service.<sup>159</sup>

### III. CONCLUSIONS AND SUGGESTIONS

Important and similar lessons can be learned from both books to help medical practitioners, veterans, veterans’ families, and the general public address the rising tide of PTSD victims. The authors of both books raise many areas where more research is needed before certain groups can be effectively addressed and treated.

One of these groups is composed of National Guard and Reserve troops, who are serving in combat roles at the highest rate ever.<sup>160</sup> A recent study by *The Journal of the American Medical Association* found that while reservists had similar battlefield experiences to active duty troops, they suffered substantially higher rates of psychological problems, including PTSD, depression, and suicidal thoughts.<sup>161</sup> This study of 88,235 active duty and reserve troops<sup>162</sup> found that 24.5 percent

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<sup>156</sup> *Id.*

<sup>157</sup> *Id.* at 53.

<sup>158</sup> *Id.* at 57 (noting that several possible strengths are resilience, compassion, irony, and courage).

<sup>159</sup> *Id.*

<sup>160</sup> MEAGHER, *supra* note 2, at 95.

<sup>161</sup> Michael Weisskopf, *The War’s Mental Toll on Reservists*, TIME, Nov. 13, 2007, available at <http://www.time.com/time/nation/article/0,8599,1683751,00.html?xid=feed-cnn-topics>.

<sup>162</sup> Ann Scott Tyson, *Troops’ Mental Distress Tracked: Early Checkups Find Fewer Problems Than Later Ones*, WASH. POST, Nov. 14, 2007, at A3, available at [http://www.washingtonpost.com/wp-dyn/content/article/2007/11/13/AR2007111301459\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2007/11/13/AR2007111301459_pf.html) (indicating that approximately 56,000 soldiers surveyed were active duty Army and about 32,000 were in the Reserves or National Guard).

of reservists had symptoms of PTSD, thirteen percent had symptoms of depression, and 35.5 percent reported an overall risk of developing mental health problems.<sup>163</sup> Comparatively, 16.7 percent of active duty troops reported PTSD symptoms, 10.3 percent reported depression symptoms, and 27.1 percent reported an overall mental health risk.<sup>164</sup> The study attributes this difference to the stresses of civilian work, worries about losing military health benefits for them and their families, and separation from their units.<sup>165</sup> Notably, these are also points that Meagher, Paulson, and Krippner identify as potential factors affecting this group of troops. Meagher notes that active duty troops have many more support options available to them and their families than reserve troops have.<sup>166</sup>

More than in any previous war, women are being placed in combat support roles and seeing violence firsthand. As previously noted, fifteen percent of active duty troops and almost twenty-five percent of reservists are women.<sup>167</sup> These new roles for women have been shown to have had a profound effect on their mental health—a 2007 VA study found that women were reporting symptoms of mental illness “at a higher rate than their male counterparts.”<sup>168</sup> Additionally, of 60,000 veterans diagnosed with PTSD, twenty-two percent of women claimed to have suffered from sexual harassment or assault, while only one percent of men had.<sup>169</sup> Due to the lack of current research on the mental toll of combat and military service on women, neither book provides any insight into what methods or policies could most help this group. However, the books note that early studies seem to show that a disproportionate number of female veterans are being affected by PTSD, indicating they are an important group on which to focus treatment and research efforts.

Another area where more research needs to be conducted is in cases where a veteran may be discharged for symptoms and behavior directly linked to PTSD. As noted above, both books discuss the

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<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> Weisskopf, *supra* note 161.

<sup>166</sup> MEAGHER, *supra* note 2, at 95.

<sup>167</sup> Cox, *supra* note 45.

<sup>168</sup> Randi Kaye & Ismael Estrada, *Female Veterans Report More Sexual Trauma, Mental Trauma*, Mar. 19, 2008, <http://www.cnn.com/2008/US/03/19/women.veterans/index.html>.

<sup>169</sup> *Id.*

prevalence of “self-treatment” and also indicate that a diagnosis of PTSD may not occur until many months after a soldier leaves a combat zone. These factors can lead to a dishonorable discharge and serve as a bar to benefits. Neither book proffered a solution for this situation. Furthermore, to date no studies have been conducted that illustrate how prevalent such cases may be. As such, more research is needed in this area to determine whether VA laws can or should be changed to address these cases so those soldiers who may fall into this category can receive benefits that would otherwise be denied.

Both books also note the importance of families and civilians supporting returning veterans and helping them to feel comfortable again in civilian society. They recognize that veterans returning from Iraq and Afghanistan now are receiving more support from the general public than when Vietnam veterans returned from their service in Vietnam, but they still find that the public needs to give more support to the country’s returning veterans. Paulson and Krippner, in particular, emphasize the fact that the returning veteran is well aware of the public’s lack of support of the war.<sup>170</sup> They indicate that this knowledge can further aggravate PTSD symptoms, such as through avoidance. Such symptoms increase a veteran’s feeling of having a stigma attached that prevents many from seeking treatment and counseling during and after service. A study of 200 military men and women found that sixty percent thought seeking mental health care would have a negative effect on their career, while more than fifty percent believed others would think less of them if they sought counseling.<sup>171</sup> Most of the 200 surveyed had “rarely or never” spoken to their families and friends about any of their mental health concerns.<sup>172</sup> Meagher suggested that one way such stigma could be removed would be to assume that all troops returning from combat are going to need some form of treatment so veterans will not have to seek treatment on their own initiative.<sup>173</sup>

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<sup>170</sup> PAULSON & KRIPPNER, *supra* note 1, at 20-21.

<sup>171</sup> Kathleen Kingsbury, *Stigma Keeps Troops from PTSD Help*, TIME, May 1, 2008, available at <http://www.time.com/time/health/article/0,8599,1736618,00.html?xid=feed-cnn-topics>.

<sup>172</sup> *Id.*

<sup>173</sup> MEAGHER, *supra* note 2, at 134.

Meagher explains that the current process of post-deployment PTSD screening and counseling was installed after a cluster of post-combat murder-suicides at Fort Bragg in 2002.<sup>174</sup> She calls the six to eight mental health questions used in the post-deployment debriefing process “superficial” and notes that military service members have reservations about answering them truthfully for fear that “they may lose a promotion, be kept from high-risk missions, be looked down upon or ostracized, or have homecoming delays if they admit to a problem during the ‘demob’ process.”<sup>175</sup>

Health assessments completed between May 2003 and April 2004 found that 19.1 percent of Iraq veterans and 11.3 percent of Afghanistan veterans had mental health problems, as compared to 8.5 percent of veterans returning from other locations.<sup>176</sup> While these assessments and counseling can be helpful tools in identifying problems immediately after service, because PTSD can be of a delayed-onset nature, follow-up needs to be completed to ensure veterans are not falling through the cracks. Notably, a 2007 Army study found that soldiers were far more likely to report mental health issues in a military screening three to six months after returning from Iraq than immediately after they returned home.<sup>177</sup>

Additionally, Paulson and Krippner think all Americans need to get involved in the war effort in some way or another, so they can have a stake in what is going on and share equally in the burdens of combat.<sup>178</sup> These efforts are suggested solutions that may help to reduce the stigma that soldiers associate with seeking mental health treatment and may help increase a soldier’s feeling that people are supporting him or her.

In conclusion, Meagher’s book is a great resource for anyone who wants to learn more about PTSD and wants to figure out how he or she can help our returning veterans. It is also very useful for veterans returning from Iraq and their families to aid them in recognizing that other veterans are dealing with the same problems. While Paulson and Krippner’s book

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<sup>174</sup> *Id.* at 28.

<sup>175</sup> *Id.*

<sup>176</sup> See Keram, *supra* note 111.

<sup>177</sup> See Tyson, *supra* note 162.

<sup>178</sup> PAULSON & KRIPPNER, *supra* note 1, at 138.

is targeted more towards medical practitioners seeking alternative ways to treat their mental health patients, they also purport to provide advice to veterans to help them through the therapeutic process. Both books provide important lessons that can be learned by all parties involved in treating and addressing the needs of our returning military soldiers. The different areas each book identifies where more research is needed are useful for Congress and government agencies to consider when making policy decisions and determining where budgetary resources can most effectively be utilized.