

Exit Wounds: Current Issues Pertaining to Combat-Related PTSD of Relevance to the Legal System

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¹Abstract

Written for those in the mental health and legal communities dealing with war veterans embroiled in the criminal justice system, this Article presents an overview of current issues pertaining to the diagnosis, assessment, and treatment of combat-related post-traumatic stress disorder (PTSD). The objective is to provide information that can assist the legal system when addressing PTSD-related issues of combat veterans charged with crimes, with a specific focus on those returning from Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). As part of this discussion, insights from clinical practice for assessing and treating combat veterans are offered and considered in light of state of the art trends from the complex and evolving field of traumatic stress studies.

I. Introduction

The damaging psychological and moral impact of battle is now well documented (Marx, 2009), making it imperative in a time of war to strive to understand and lessen this harm on returning service members and society. Equally critical to appreciate is that a trauma such as combat is a shared experience. For the soldier, this begins in the battlefield with the trauma of warfare shared amongst comrades in arms, though its impact does not end there. As these soldiers come home *with* war, family members affected by the changes in their returning loved ones will

themselves change as a result (Gavaloski & Lyons, 2004).

The ripple effect of the war experience extends well beyond the immediate family. Disparate communities across America will be impacted by these returning soldiers—an impact that often extends to the criminal justice system. As Judge Robert T. Russell (2009) of the Erie County Court wrote, “The potential problems facing our nation’s veterans are numerous. These issues will likely require assistance and collaboration from countless professionals within our communities, including the courts, to even begin to combat them” (p. 132).

This Article will look at issues pertaining to PTSD that surface when the legal/judicial community deals with service members and veterans returning from deployment to a combat zone. It is written from the perspective of a psychologist who assesses and treats war returnees with the goal of mining this direct clinical experience for insights pertaining to the lived experience of returning service members.

II. PTSD: An Evolving and Dynamic Diagnosis

PTSD is a complicated and controversial psychiatric diagnosis. As Judith Herman (1992) describes in her classic text, *Trauma and Recovery*, there has been long-standing historical ambivalence and debate regarding how to best understand and interpret the impact of traumatic experiences on the human psyche. And this debate has accompanied the continuing evolution of this diagnosis, which has only been officially recognized for thirty years now (Summerfield, 2001). The following brief outline concerning the changes in the diagnosis of PTSD since its inception is

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presented to highlight that our understanding of this disorder—as well as the related diagnostic criteria—shifts with advances in theory and research. This can present challenges to attaining precision and consistency in diagnosis and care amongst mental health practitioners. Additionally, divergent views of PTSD and inconsistent perspectives and debates on its diagnosis and treatment can pose challenges to those in the legal system as they strive to understand its significance to criminal behavior.

The mental health field's primary diagnostic guide is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. In the original 1952 edition, the DSM used the phrase "gross stress reaction" to address posttraumatic reactions. The thinking at the time was that "anyone" could temporarily "break" under enough pressure, but that most people recover with support and care (American Psychiatric Association, 1952). Those individuals who did not recover were viewed as having underlying psychological problems that went beyond exposure to a stressful event.

In the next iteration in 1968, "gross stress reaction" was replaced with "transient adjustment disorder of adult life," which many felt demoted and denigrated the status of psychic trauma (Brewin, 2003). However, chiefly as a result of the Vietnam War and outspoken and deeply committed activist war veterans, the concept and impact of trauma was reinserted and strengthened in the DSM-III with the inclusion of the diagnosis of PTSD in 1980 (Herman, 1992). Increased examination of the psychological effects of trauma in general—and combat in particular—ensued (Friel, White, & Hull, 2008).

In formulating the PTSD diagnosis, the DSM-III broke tradition by deviating from the approach used with all other existing psychiatric diagnoses when it linked the causation of a mental disorder to an external traumatic event (Brewin, 2003). This traumatic event was described as "a

recognizable stressor that would evoke significant symptoms of distress in almost everyone" and that was "outside the range of common human experience."

Acceptance of the impact of trauma continued to gain momentum and in the 1994 DSM-IV revision, the rarity of the triggering event was removed. Instead, greater emphasis was placed on one's subjective experience and *perception* of the event. Further, the availability of a PTSD diagnosis was expanded to include those individuals with *indirect* exposure to horrific and disturbing events (American Psychiatric Association, 1994)—a change that received significant criticism. McNally (2004) observed that such a broadened definition resulted in "conceptual bracket creep." With both secondhand exposure and direct experience encompassed under the "stressor rubric," and with a new emphasis on a victim's subjective reaction, he wrote: "To qualify as a trauma survivor, one need only respond with fright to learning about the misfortunes of others, including strangers." (p. 815)

Since 1994, the diagnostic criteria require a traumatic stressor (Criterion A) that has two parts. An individual must have "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and "the person's response [must have] involved intense fear, helplessness, or horror." The stressor must also induce symptoms falling within the following three domains or cluster areas: re-experiencing of the event (Criterion B), avoidance (Criterion C), and arousal (Criterion D). Also necessary for a diagnosis of PTSD is a duration of symptoms for more than 30 days (Criterion E), and "clinically" significant distress and functional impairment (Criterion F). The three symptom cluster areas of re-experiencing, avoidance, and arousal encompass a total of seventeen specific, core symptoms. For example, re-experiencing contains five symptoms, such as nightmares and flashbacks. Not everyone diagnosed with PTSD will have each of the

seventeen core symptoms but a diagnosis requires some from each of the three domains.

New changes are proposed for the DSM-V slated to debut in 2013 (APA, 2010). The currently imposed subjective response to a stressor that has long been considered problematic will most likely be eliminated. Members of the military, for example, rarely endorse this requirement, usually noting the absence of an emotional reaction at the time of a traumatic event.

Additionally, even more profound changes in this diagnosis are also recommended based primarily on advances in research and treatment (Asmundson & Taylor, 2009; Pietrzak & Southwick, 2009). The three cluster areas (Criteria B and C) and the symptoms associated with each of them are being reworked to reflect distinctions now considered important. For example, Criterion B would reference “intrusion symptoms” (versus re-experiencing symptoms) and would clearly identify dissociative reactions as a possible symptom. In DSM-V, as a result of research pointing to another core symptom cluster area, Criterion C would focus solely on avoidance, while a newly designated Criterion D would encompass symptoms that reflect negative alterations in thinking and mood and would include self-blame and a wider variety of negative emotional states beyond that of “fear, helplessness and horror.” Further, the symptom cluster area of alterations in arousal and reactivity would become Criterion E. A notable shift in emphasis in the new Criterion E is the listing as symptoms irritable, angry, and aggressive behaviors and reckless and self-destructive behaviors. In DSM-IV, the emphasis is on feelings of anger rather than on acts reflecting this emotion.

In addition to the basic conceptualization of PTSD, and the possible proposed changes in diagnostic criteria, this disorder is increasingly being viewed along a continuum of severity. Hence, there has been professional recognition of the concept of subthreshold, subsyndromal, or partial PTSD (“PTSD light,”

as it were). However, there is no “universal” definition for what these classifications mean or encompass (Breslau, Lucia, & Davis, 2004; Jakupcak et al., 2007; Pietrzak, Goldstein, Malley, Johnson, & Southwick, 2009). At times, these terms are used to connote individuals who do not meet the entire criteria for PTSD, while at other times they are used to refer to individuals with only moderate symptoms (Zlotnick, Franklin, & Zimmerman, 2002). Researchers Mylle and Maes (2002) have suggested that the impetus for these distinctions was to broaden the assistance available to individuals with similar conditions and to not be overly restrictive regarding the plight of those with possible PTSD. However this expansion raises questions whether the same treatment approaches may apply to all gradients of trauma sufferers.

Further complicating diagnosis and treatment is the fact that PTSD rarely shows up alone. Co-morbid disorders are the rule. Eighty percent of individuals with a PTSD diagnosis will meet criteria for at least one other psychiatric disorder (Kessler, 2002). Commonly also found are depression and generalized anxiety, each of which can also occur by itself in the aftermath of trauma exposure. Co-morbidity can complicate both diagnosis and treatment. Many features of PTSD resemble other disorders—for example, a sense of a foreshortened future and memory problems, which are two widely seen symptoms of PTSD, can also be signs of depression. Similarly, hyperarousal symptoms, another possible indicator of PTSD, are also consistent with a diagnosis of an anxiety disorder.

The PTSD diagnosis remains actively debated with advocates and skeptics presenting vastly divergent points of view (Brewin, 2003). Richard McNally (2005) writes:

From the beginning, critics of the PTSD diagnosis wondered whether its advocates had discovered a disease entity in nature or whether they had cobbled together a cluster of symptoms shared with other syndromes and then traced its etiology to

the unpopular war in Vietnam. Was PTSD discovered by clinical scientists or created by them? (p. 815)

There are both significant scientific controversies and important unresolved questions that go to the very validity of the PTSD diagnosis. This Article will discuss the implications of this debate, but first the state of the art in PTSD assessment will be examined.

III. The Assessment of PTSD

To establish a PTSD diagnosis, it is necessary to (1) consider the nature of the traumatic event (Criterion A), (2) look for symptoms within each of the three cluster areas, and (3) note a causal link. Because it is psychometrically sound and easy to use, the “gold standard” assessment tool in PTSD diagnosis is the Clinician-Administered PTSD Scale, or CAPS, a structured, interactive diagnostic interview (Blake, Weathers, & Nagy, 1995). Initially developed with combat veterans, it evaluates the frequency and intensity of the 17 core symptoms and usually takes at least an hour to administer.

Employing this instrument, symptoms are discounted as indicators of PTSD if they do not meet a requisite level of frequency and intensity. That is, someone may endorse the presence of a symptom but demonstrate little or no distress. Clinicians can thereby identify which are the dominant symptoms and how much functional impairment there may be. Perhaps not surprisingly, the CAPS is primarily used in forensic settings and in research protocols where accuracy is imperative.

There are other sound PTSD diagnostic tools available. For example, there are self-report measures such as the Posttraumatic Stress Disorder Checklist (PCL). This instrument requires participants to rate the severity of each symptom during the previous 30 days on a scale ranging from one (not at all) to five (extremely). Reliance on self-report measures, however, as discussed below, is not considered the best means of making a

diagnosis. These checklists are useful for gathering information but a diagnosis should be made only after further query by a skilled mental health practitioner.

Many clinicians practicing in the field do not routinely use standardized measures for assessment or to monitor treatment progress. Mental health professionals have cited practical as well as philosophical reasons for this (Hatfield & Ogles, 2007). Practically, establishing an ongoing system using such measures is seen as difficult and time-consuming. Philosophically, these measures are not always seen as helpful or contributing added value to their clinical practice. This may have contributed to findings that the application of this psychiatric diagnosis has low to moderate reliability (McHugh & Treisman, 2007). Further, when the DSM-V is published, it is likely that existing reliability measures will need to be revised and restandardized to reflect changes made to the criteria for diagnosing PTSD.

As indicated, another key issue in the assessment of PTSD-specific symptoms is that the diagnosis is based upon a client’s self-report. In traditional clinical practice, the prevailing presumption is that what a client says is true, or is at least grist for further exploration. But a client’s depiction of a traumatic stressor, the prerequisite in establishing a PTSD diagnosis, is often impossible to verify. The assessment of symptoms has been noted in the literature as the most crucial step in establishing the PTSD diagnosis (Grover, 2007). A central dilemma stems from the subjective nature of the symptoms, and therefore the risk of malingering or establishing a factitious PTSD for either financial gain or to diminish or to avoid responsibility for a criminal act (Sparr & Pankratz, 1983).

For example, in the Veterans Administration (VA) Healthcare System, the reimbursement for psychological injury incurred during military service requires linkage of PTSD to military service. At the same time, financial compensation for this disorder is often viewed

as “rewarding” and supporting illness (versus wellness), diminishing engagement in treatment, and promoting chronic disability. PTSD is the most common mental health disorder for which veterans apply and receive disability compensation (Sayer, Spoont, & Nelson, 2004). The VA is a major source of financial compensation for veterans, with the greater the VA service connection disability rating, the greater the financial gains and other benefits, such as college payment for children (United States Department of Veteran Affairs, 2010). As Rosen and Spitzer (2008) observed, “VA policies likely interact with disability convictions and chronic presentations of PTSD.”

Malingered or exaggerated PTSD symptoms preclude obtaining an accurate accounting of the prevalence of PTSD and an understanding of its true nature and impact (Laffaye, Rosen, Schnurr, & Friedman, 2007; Ramchand et al., 2010). As a result, some scholars argue that a consideration of the possible presence of malingering should be directly incorporated into the DSM-V diagnostic criteria for PTSD (Spitzer, First, & Wakefield, 2007).

A claim of PTSD may also be increasingly acceptable to many war returnees for other less exploitive reasons. The ascription of post-deployment psychological issues to the trauma of combat may be more palatable to some than admitting to other mental health problems or pre-existing adjustment or other psychiatric issues such as antisocial behavior. Combat PTSD may be viewed as a “badge of honor” from the battlefield that skirts a more humbling explanation for perceived emotional flaws or weaknesses.

In a study focusing on veterans seeking disability compensation for PTSD from the Department of Veterans Affairs, most claimants reported seeking disability compensation for symbolic reasons, especially for acknowledgement and validation for their suffering in general and for relief from self-blame. Seeking to improve finances was less frequently endorsed as the

reason for raising a claim of PTSD (Sayer et al., 2004).

IV. PTSD Treatment and the Combat Veteran

PTSD is now considered a treatable disorder. For example, the Veterans Administration currently promotes a mental health recovery model nationwide that includes targeted PTSD treatment “rollouts” in which practitioners are trained in evidenced-based treatments understood to effectively address the symptoms of PTSD (Ruzek, Friedman, & Murray, 2005).

Best practice treatment guidelines from the Veterans Administration and the Department of Defense (United States Department of Veterans Affairs/Department of Defense, 2004), the International Society for Traumatic Stress Studies (Foa, Keane, & Friedman, 2000), and the American Psychiatric Association (Ursano, Bell, & Eth, 2004) unanimously recommend cognitive behavioral therapy (CBT) as the first line of treatment for PTSD. Medication is not considered a first line of treatment for this condition, although it can be helpful under certain circumstances, such as when clients are finding it hard to initiate psychological therapy or express a clear preference to avoid “talk” therapy. In general, CBT is based on an application of learning theory. Problems or disorders are viewed as learned cognitions, with changed behaviors and therapy viewed as the incorporation of new learning.

For the combat veteran with PTSD, CBT is considered the treatment of choice. At present, there are no uniquely veteran or military focused evidence-based PTSD treatments with a solid evidence base. The evidence base for successful PTSD treatments was established in the civilian world, chiefly with sexual assault victims. But increasingly, more research is being conducted with war returnees to assess utilization and success rates of the treatments for this population.

The recommended efficacious, cognitive-behavioral, evidence-based treatments that exist for this disorder are short-term (eight to fourteen sessions) and highly structured. Present day state of the art treatments for PTSD include Edna Foa's Prolonged Exposure (PE) therapy (Foa, Hembree, & Rothbaum, 2007) and Patricia Resick's Cognitive Processing Therapy (CPT) (Resick & Schnicke, 1993), and these are the two therapies primarily promoted currently by the VA.

These treatments embrace the perspective that PTSD is surmountable. The overall philosophy of each is to remove "blocks" to recovery. In PE therapy, the barrier to recovery is seen as stemming from PTSD-related avoidance. Past painful and horrifying memories of the traumatic event, as well as current triggering situations, are circumvented by the patient with PTSD. As a result, needed healing emotional processing is curtailed and PTSD symptoms remain in place. Treatment involves the careful and systematic direct confrontation of these memories and situations through two kinds of exposure: imaginal (recollecting the dreaded event in one's mind) and in vivo (facing in person fear-inducing, trauma related situations) (Foa & Kozak, 1986).

In CPT, there is less emphasis on exposure and more on increased cognitive processing. It is a more "frontal lobe" approach, geared towards addressing errors in thinking patterns rather than altering one's emotions. Applying CPT, this approach asserts that what interferes with recovery is the cognitions and world views that have become distorted through exposure to the traumatic event. Hence, thinking patterns are directly and purposively challenged through in-session dialogue and between-session homework assignments. In both PE and CPT, the hierarchical gap between provider and client is reduced and the therapist is viewed as more of a coach who engages and expects the full participation of clients to achieve treatment goals.

It should be noted that although there are established treatments to reduce PTSD symptoms, access to such treatments in the community is limited. In 2008, the Institute for Disaster Mental Health at the State University of New York at New Paltz hosted a conference entitled "Healing the Scars of War." Attending mental health practitioners were surveyed online by Institute director Dr. James Halpern and his findings presented at the 2008 International Society for Traumatic Stress Studies' annual conference (Halpern, 2008).

The survey was administered to 132 community-based practitioners regarding their work with military personnel, recent veterans, and their families. Most of these clinicians did *not* believe that they had a sufficient understanding of military culture to be effective, nor did they consider themselves to be familiar with relevant research literature. Further, they did not appear to practice according to established best-practice guidelines, nor did they view it as important for them or for their colleagues to practice according to these guidelines.

Further, they were generally not confident in their ability to deliver services across a range of potential modalities and treatment domains in working with this population. When asked about the gaps in their knowledge of the research literature, responses clustered around six meta-themes: they felt deficient in (1) assessment and treatment, (2) specific symptoms in military personnel, (3) aspects of military culture affecting treatment and symptomatology, (4) community and ecological factors, (5) training, and (6) working with military families.

This sample, though small, suggests that practitioners in the field are not delivering state of the art therapies to military veterans. As noted, the VA is seeking to enhance the availability of these treatments to veterans, although there are no data yet as to the success rate of this effort. If not linked to the VA, community mental health practitioners will need to be proactive and dedicated in their

efforts to access training options if they are to develop competency in treating war returnees.

It should also be noted that veterans wishing to engage in either PE or CPT—the state of art treatments for PTSD—must possess a certain level of stability. These treatments are “trauma focused.” They require the client to have the emotional stamina to confront memories, emotions, thoughts, and situations that they have been avoiding. Hence, veterans who may become psychotic or suicidal or who are not able to moderate their use of alcohol or drugs are not candidates for these therapies (Resick et al., 2008). Participants must be able to focus, complete homework, and limit the inherent avoidance that often drives those with PTSD out of treatment.

As discussed in the next section, stressors inherent to post-deployment reintegration may affect the ability of war returnees to enter treatment. Developmentally, many of these individuals are quite young and at a point in their lives when they must accommodate competing and potentially stressful tasks such as securing employment, dating, completing school, and raising children.

In fact, a recent study looked at the utilization of mental health services by Iraq and Afghanistan veterans receiving care at Department of Veterans Affairs (VA) facilities. Of 49,425 veterans with newly diagnosed PTSD, under 10% of them appear to have received what would approximate evidence-based mental health treatment for PTSD at a VA facility in the first year following diagnosis (Seal et al., 2010).

Further, barriers to seeking mental health treatment for veterans returning from warzones are very real (Hoge et al., 2004). Although early treatment might help them retain their relationships and avoid developing related problems like depression, alcoholism, and criminal behavior, many do not seek or get such help. Within the military community (as well as the larger society), there is a tremendous amount of stigma associated with

seeking mental health treatment. As one Marine stated, *“In the Marines, you might as well just lie down and cry for your mommy if you go for mental health services.”* Such stigma prevents many from seeking mental health services. Those who hope to work in professions such as law enforcement and other positions that require security clearances fear that seeking mental health care will reduce their chances of getting hired. Additionally, some clients have a distrust of the VA because of its association with government, and as a result resist obtaining treatment from the VA.

V. Risk and Resilience Factors

One potentially complicating issue is that scientific findings challenge the notion that traumatic events are the sole cause of PTSD symptoms. Exposure to salient adversity, including that of combat, does not necessarily lead to impairment and illness in all people. This has led some experts to assert that PTSD is a qualitatively distinct response to extreme stress that will eventually be explained by a distinctive pattern of psychobiological abnormalities. Other experts, however, contend that PTSD falls along the “normal” stress continuum response and, therefore, anyone can develop this syndrome (Resick, 2001).

Not everyone exposed to combat or other traumatic events is at equal risk for experiencing posttraumatic symptoms. Responses vary. A traumatic event therefore does not inherently result in the development of PTSD (Bodkin, Pope, Detke, & Hudson, 2007). Mediating factors that may be quite influential include a successful fight or flight response (i.e., responding adequately during a traumatic event), one’s belief systems (e.g., having confidence in one’s abilities to manage difficulties), and internal and external resources, including positive support from family, community, and social networks. All of these may affect the impact of a traumatic event.

Risk and resilience factors are those factors or circumstances that are associated with negative or positive outcomes, respectively. A risk factor—whether a characteristic of the event, the person, or the environment—is associated with a likely increase in a negative outcome. Resilience factors are those factors that endow those individuals exposed to a traumatic event with a greater ability to cope with that event.

Commonly identified risk factors—not exclusive to combat—include female gender, being younger in age, lower socioeconomic status, lower IQ, prior and ongoing psychiatric problems, heightened level of exposure, the presence of loss and bereavement, injury, heightened level of horror and life threat, lack of social support, and subsequent life stressors. In two meta-analyses (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2008), the combined influence of prior trauma history, prior maladjustment, family history of psychopathology, and lack of social support contributed substantially more to an adverse outcome than specific event characteristics.

In a 2009 study (Larson, Booth-Kewley, Highfill-McRoy, & Young) examining the psychiatric risk factors of Marines sent to war, the identified key risk factors were low pay-grade, hospitalization during deployment, low education, pre-service smoking, PTSD symptoms endorsed upon return from service, interpersonal conflict, sick call visits in the war zone, pre-military life history of trauma, and relatively lower intelligence. The authors did not find that the nature of war zone combat exposures were predictive of post deployment psychiatric disorders.

The Department of Defense is purposively striving to augment the capacity for psychological resilience in its war fighters. *Resilience* refers to the ability to bounce back from crisis and to persevere. It reflects the fact that most soldiers exposed to combat return without seeking treatment and are able to make a functional adjustment. However, resuming functioning is a broad concept and a

significant level of internal distress can be present despite external accomplishment.

As noted at the beginning of this Article, when service members deploy, other individuals around them are also affected, which complicates the trajectory of their return. As noted with regard to identified risk and resilience factors, *positive* social support mitigates the adverse impact of traumatic exposure, while *negative* social support greatly increases the risk for disruptive post-traumatic distress.

What do combat returnees need when they return from war? To address this question necessitates an examination of the realities of the deployment cycle and the challenges of reintegration into society.

VI. Immediate and Long Term Impact: The Deployment Cycle

Deployment is defined as a service member's activation to serve in a particular mission. Career soldiers and now reservists alike can be called upon to bear arms for their country in a duty station far away from home. *The Deployment Cycle* is the phrase used to connote the three broad phases of this process: pre-deployment, deployment, and post-deployment.

Each phase involves unique characteristics and challenges. Pre-deployment includes notification and preparation for deployment. It is a "ramping up" period that can last anywhere from two weeks to two months. Deployment encompasses departure for service, separation from one's usual surroundings and loved ones, and sustainment of oneself while in the field. During this phase, those activated typically work in dangerous and stressful environments and live apart from their loved ones for seven to fifteen months. The post-deployment phase includes the return home, followed by reunion and reintegration. In the past, this was seen as the terminal phase of the cycle. However, today, many returning soldiers must contend with the stress of another deployment

soon after their return stateside. Thus, reintegration post-deployment is a process that can span years.

A. Pre-Deployment

New stresses begin with the first notification of impending deployment. Often there is very little notice and too little information about the length and destination of deployment. The departing service member begins to psychologically be more focused on the mission ahead and his or her comrades rather than the needs of family or work, often becoming preoccupied with preparations to mobilize.

During pre-deployment, preparation is both practical and emotional. Service members review wills, financial plans, and powers of attorney. Emergency contact procedures are established and contingency childcare arrangements devised. Everyone tends to contemplate a range of potential adverse outcomes, but must still move forward with faith in the mission and trust that the soldier will be protected and return.

A 2004 Department of Defense Survey indicated that over 80% of the Army's enlisted soldiers are under the age of 35 with a mean age of 27 (Military Family Resource Center, 2006). Fifty-one percent of their children were under the age of seven, with half under three years old. Thus, individuals contending with these stressors are often very young. They are at a point in their family life cycle when they are still forging their roles and lives together with their partner, but now they must begin to address what life would be like if the deployed service member is killed or seriously injured in the line of duty.

B. Deployment

At the heart of the deployment phase are the combat experience and the separation from family and other loved ones. The tough realities of war include that: combat is harsh and demanding; combat impacts every soldier mentally and emotionally and has lasting

mental health effects; combat poses moral and ethical challenges; fear in combat is ubiquitous; and unit members most likely will be injured and killed (Riggs, 2008). All family members, adult and non-infant children, know these realities and live with the uncertainties that these bring before, during, and after a deployment.

Deployments are identified as the top challenge by Army spouses (Booth, Segal, & Bell, 2007). For the service member, difficulty balancing duty and family demands is the most frequent reason for leaving the Army (Hoge, Auchterlonie, & Milliken, 2006).

Today's military forces face more frequent and less predictable deployments. One can imagine the tension this creates within a family. Studies have found that family members become less satisfied with the military way of life as length, frequency, and unpredictability of deployments increase (Milliken, Auchterlonie, & Hoge, 2007). In a survey of Army spouses, 85% reported loneliness (Riggs, 2008). They listed missing companionship and intimacy, as well as the absence of those deployed during significant family occasions, as significant life-stressors.

Moreover, the reserve component of the military may experience additional burdens. Many lose income and have an increase in childcare needs and expenses (Milliken, Auchterlonie, & Hoge, 2007). Army National Guard troops and the routine activation of military Reserve units is now common with these groups representing 20% of all deployed. Guard troops and Reservists have often been referred to as the "citizen Army" of this country and they and their families live in the midst of civilian neighbors. Most do not live near active duty military facilities with their substantive resources available to assist them. Generally, there is no formalized social network to support the Reservists or National Guard families when their loved ones are in training or in overseas deployment areas.

In a later section, the stressors encountered by the service member while deployed to a combat zone will be spelled out.

C. Post-Deployment: Coming Home

Though deployments are highly disruptive, the “typical” course of reintegration attests to the fact that most service members, along with their families and loved ones, are able to manage the ensuing course of events. Still, reunion is stressful. Most practitioners readily assume that service members will be changed by their combat zone experience, but may overlook the fact that the families of service members are also strained and changed by the absence of their loved ones (Kessler, 2000). Changed soldiers return home to changed families, and the expectations of returning soldiers and their loved ones are often conflicting and mutually confusing (Mikulincer, Florian, & Solomon, 1995). In a 2004 through 2005 U.S. Army Community and Family Support Center (CFSC) Survey, the following were the top sources of post-deployment adjustment difficulties noted by families: psychological changes in spouses, handling children, re-establishing roles, communication, household routines, decisionmaking responsibilities, children’s expectations, and marital intimacy (Riggs, 2008).

Further, the excitement of homecoming can promote unrealistic beliefs about reunion. Couples unexpectedly discover that they require time to re-establish physical and emotional intimacy, leading to a sense of disappointment or disillusionment. In many instances, a traumatized soldier is greeting a traumatized spouse and neither is “recognizing” the other (Hoshmand & Hoshmand, 2007). Many soldiers are finding that neither they nor their spouses are able to cope with the changes in their relationships. Those returning from a war zone find it difficult, if not impossible, to share their experiences with those closest to them. Typically, they choose not to share details about what they have been through with loved ones, friends, or co-workers, thus causing

further estrangement as those closest to them cannot put such experiences into context.

Service members return from deployment with a “battlefield mindset.” It is common to have some PTSD symptoms at first—especially hypervigilance, insomnia, and nightmares—as veterans try to integrate and process their war zone experiences. These symptoms are likely to be more intense for those who have returned recently, and many of these symptoms are likely to decrease over time as they adjust to civilian life. But while emotional steeliness, mission focus, hypervigilance, and distrust serve the soldier well in war, they are often maladaptive at home. Returning soldiers feel as if they are still “in country”—closer to the military mission and those with whom they served than to their spouse and children. For them, nothing else may seem as important for awhile. Couples and families tend to expect to resume where they left off, but each will need to appreciate what the other has been through as they “reinvent” their family together again. This is a period of transition with accompanying mixed and unsteady emotions—joy, resentment, relief, and anxiety—that takes individual and collective effort to accommodate, as well as the passage of time.

VII. The Unique Context of Combat

Specific attention needs to be given to the context of combat to deepen understanding of the experience of the service member. The conditions of battle include both human agency and mass violence, factors associated with higher levels of traumatization.

Military cultural values and ideals are indoctrinated during basic training. This occurs across all branches of service (Army, Navy, Marines, and Air Force). This indoctrination includes fostering a strong reliance on one another (e.g., viewing each other as a “band of brothers”), and core values of loyalty, duty, respect, selfless service, honor, integrity, and personal courage. “Mission first and soldier always” is taught immediately. In combat, the

relationship among comrades helps defuse stress. Such bonds are rarely replicated in the civilian world, save perhaps for those in specialized paramilitary occupations such as that of firefighting or policing. Consequent to this training, what happens to another soldier is of profound psychological significance to the individual (O'Brien, 1990). Soldiers feel responsible for each other, pledging when sworn into duty not to leave another service member behind. They "have each other's back" in life-and-death situations. This is a profound commitment in which the needs of the self are subordinated to the mission and to other soldiers. Esprit de corps is a paramount value and essential to survival.

In present day combat, when soldiers are in a theatre of war and in need of psychological support, they are kept close to their unit as unit cohesion has proven to be the most significant protective factor against the development of PTSD. The Department of Defense published a directive in 1999 on combat stress control (Department of Defense, 1999) that articulated the basic concept of PIES—Proximity, Immediacy, Expectancy, and Simplicity—as providing the basis for basic, immediate treatment with the expectation of return to duty (Ritchie, 2007).

Survivor guilt following death, injury, or the terrible suffering of another service member is a very real and perhaps underappreciated phenomenon. Generally viewed as a traumatic stress reaction, survivor guilt is derived from identification with and a sense of responsibility for those hurt or killed (Lifton, 1980). It can obstruct post-traumatic recovery and have profound psychological effects. Characterized by cognitive distortions or misappraisals, surviving soldiers often feel they did not do enough to help or save others or that they are somehow unworthy of having been spared (Halpern & Tramontin, 2007). Ironically, this may be in stark contrast to how much they actually did do or even how heroically they acted. Indeed, being labeled a hero for their actions may increase these internal, negative self perceptions and heighten a sense of inadequacy. The close

identification with one another leads to a sense of "It could have been me," or "It should have been me." Although, quite painful, ultimately such guilt may serve a defensive or protective function against even more confusing feelings of powerlessness and a sense of the arbitrary randomness of events occurring beyond anyone's control (Wayment, 2004). A sense of control is a cherished value for those fighting a war.

Mourning the loss of fellow soldiers while in a combat zone may be nearly impossible for the service member as he or she must maintain emotional control and focus on mission and survival. Death on the battlefield may also have special features that complicate the grief process. Those killed in combat often die in uniquely troubling circumstances heightening the experience of traumatic loss. Sudden and unanticipated death in horrific circumstances is harder to accept, especially when, as in war, it is the result of an intentionally malicious act. Furthermore, there may be no bodily remains, or the body may no longer be whole or be in a terrible condition, or there may be obstacles to retrieving a body. Quite often, service members have to search for and handle the remains of their comrades. Some are part of specialized units in which it is their duty to oversee the return of human remains and so are confronted on a daily basis with the untimely and horrific death of peers. Marine Major Eric Young (2007) observed in an article in the *Marine Corps Gazette*:

There are real dangers to a Marine's mental state when dealing with human remains and viewing the devastation an improvised explosive device can cause to a body. . . . Every leader needs to be aware of the negative effects of dealing with death and human remains and the toll it can cause on the psyche. The mind is not calibrated to accept the violence seen in the performance of PRP (Personnel Retrieval and Processing) duties and in combat. Strange thoughts, dreams, and feelings are absolutely normal; not wanting to look at the remains of another Marine is acceptable. As leaders we must be able

to explain that these feelings are normal, acknowledge these ideas, and move on. (p. 39)

A key factor in addressing combat-induced PTSD is to recognize the level of sustained exposure that occurs in the field. Current Army deployments usually last for one year or longer; Marines deploy for seven months, while specialized units in the Navy and Air Force face deployments that are around three to four months long. Multiple deployments are not uncommon. Studies have shown that longer deployments lead to more potentially negative consequences and that an optimal military deployment for mitigating adverse impact is one that lasts between two and four months (Adler, Huffman, Bliese, & Castro, 2005; Kline et al., 2010). In terms of understanding the nature of sustained exposure during a combat deployment, it is important to know what a given deployment involved. Some military occupational specialties (MOS)—such as infantry—carry more risk and exposure and less respite from danger. But it is important not to make assumptions regarding their impact because the nature of battle is fluid and assignments can change quickly, which in itself provokes additional stress.

Nevertheless, while imminent danger fluctuates, deployed service members are in a setting that requires continuous arousal and threat scanning. High alert in the field saves lives. In contrast, victims of traumatic events occurring in non-war zones are cared for quite differently, as they are often immediately provided recovery environments in which safety is restored and the heightened arousal level is reduced, so that the healing and processing can begin. The goal of combat operational stress interventions in the field, however, is to restore the soldier to his or her comrades in arms and to continue with the mission.

In combat, killing another human being is a significant possibility. Service members are trained to kill and barriers that limited this ability in the past were effectively addressed

by the military after early studies showed that there was a reluctance to engage in this action even when necessary (Grossman, 1996). But there are often unanticipated psychological consequences that result when service members kill an enemy combatant, kill women and children used as bait or shields by the enemy, inadvertently kill innocent civilians, or kill other service members in “friendly fire” accidents (Maguen et al., 2010). Despite training and the necessity of the moment, killing and the possibility of killing can create significant psychological conflict. In a 2005 book of poetry entitled “Here, Bullet” based on his experiences in the infantry in Iraq, Brian Turner (2005) reflected on this in his poem entitled “Sadiq” which opens with *“It is a condition of wisdom in the archer to be patient because when the arrow leaves the bow, it returns no more . . .”*

It should make you shake and sweat,
nightmare you, strand you in a desert
of irrevocable desolation, the consequences
seared into the vein, no matter what adrenaline
feeds the muscle its courage, no matter
what god shines down on you, no matter
what crackling pain and anger
you carry in your fists, my friend,
it should break your heart to kill. (p. 56)

And it is not just the act of taking a life that can be conflictual. There are many events and circumstances in a warzone that are ambiguous, horrific, or strange that layer the combat theatre exposure with added pressure and dynamic tension. The perpetration and witnessing of atrocities is associated with PTSD symptoms and ongoing psychological distress (Haley, 1974). Unlike many other traumatic experiences, combat can cause “moral pain” arising from “the realization that one has committed acts with real and terrible consequences,” according to a seminal 1981 article by Peter Marin. He used the term “moral pain” to discuss the spiritual, philosophical, and existential questions arising in war but rarely addressed clinically or socially upon return. As Benedicta Cipolla (2007) wrote in “Healing the Wounds of War:”

Witnessing death and suffering also goes to the heart of life's meaning: "Why did God, if there is a God, allow this? Why is killing the enemy not a sin? How can I be forgiven? Why couldn't I save my comrade? Why am I alive when I don't deserve to be?" Psychology isn't always equipped to answer such questions.

Psychologist Edward Tick in his 2005 work "War and the Soul" makes the case that this moral pain injures the soul and is a root cause of PTSD. In his formulation for healing our service members, he considers it essential to address the needs of the shattered soul.

Litz et al. (2009) advocate that moral injury stemming from war zone exposure is a separate phenomenon that is not directly addressed by current evidence-based PTSD treatment. They argue for the increased study of combat-related moral injury and propose specific ways of intervening to target the specific issues involved. They observe:

Service members and veterans can suffer long-term scars that are not well captured by the current conceptualizations of PTSD or other adjustment difficulties. We are not arguing for a new diagnostic category . . . nor do we want to medicalize or pathologize the moral and ethical distress that service members and veterans may experience. However, we believe that the clinical and research dialogue is very limited at present because questions about moral injury are not being addressed. In addition, clinicians who observe moral injury and are motivated to target these problems are at a loss because existing evidence-based strategies fail to provide sufficient guidance. (p. 696)

Similarly, a noted PTSD scholar, psychiatrist Chris Brewin (2003), writes about the phenomenon of mental defeat in those who are exposed to trauma. He views this occurrence as a surrender of one's sense of personal agency and notes that the reaction extends beyond feelings of helplessness and

can instead rock the core of one's identity. Thus, it is important to monitor meaningful post-deployment changes even though they may not constitute PTSD, as they may severely impact the quality of life. Service members after enduring combat often experience subsequent anxieties of an existential nature, reactions that relate to issues of meaning, sense of self, and identity.

Indeed, the experience of combat stress has the potential to fragment one's sense of self. Identity and self relate to the notion of consistency or sameness over time. Trauma, however, disrupts the meaningful organization of the self and the world, often leaving individuals feeling helpless, hopeless, and worthless. Stern (1985), a psychiatrist who has studied the development of the self, writes, "Sense of self is not a cognitive construct. It is an experiential integration." In other words, the self is a unifying system that can become burdened under the pressures of incorporating experiences that are overwhelmingly stressful. Clinicians working with veterans have long noted that PTSD is a disorder of identity characterized by a failure to integrate aspects of identity, memory, perception, and consciousness.

This integration extends beyond managing traumatic memories or dreams, or one's irritability and intrusive ideation, to include a quest for meaning after bearing witness to the unimaginable. Functioning in the world is mediated by implicit assumptions that organize thoughts, feelings, and actions, but severe stress leads to a reconfiguration of deeper self-schemas. Harvey (1998) notes, "After such colossal mental and behavioral revisions, the survivor may wonder, 'who am I anyway?'" Following exposure to combat, the conclusions drawn about one's self and the world can be negatively distorted, thereby contributing to subsequent distress and making it difficult to place such an intense experience in the past.

The ultimate task then is to integrate what one has been through into a changed but intact identity and come to terms with how a trauma

has changed one's self-concept, relationships, and aspirations. Family members of soldiers who return from war often comment that their loved ones are "not the same." There are issues of functional adjustment (being able to adapt to the demands of daily life), as well as issues associated with one's broader happiness and quality of life.

As a result, because there are so many traumatic events naturally occurring in a combat theatre, returnees often find it difficult to pinpoint the one that may have been a turning point that defeated their efforts to manage and deal with stressors moving forward.

VIII. Long-term Impact: The Legacy of Combat Trauma

Those returning from a war zone are confronted with a range of long-term challenges. Psychologically, they may be experiencing post-traumatic distress, ranging from mild to severe. They may also be contending with significant physical and mental health consequences that pose a special hardship for all involved (Hutchinson & Banks-Williams, 2006).

For example, traumatic brain injury (TBI), often called the "signature wound" of the current conflict, can be linked to persistent headaches, short-term memory problems, concentration difficulties, and trouble with balance. According to a 2008 RAND Corporation study, approximately 320,000 soldiers have experienced some form of traumatic brain injury (Tanielian & Jaycox, 2008). Improvements in armor and medical treatment allow soldiers to survive explosions, but they then suffer their delayed effects. These brain injuries range from mild to severe. For those whose TBI falls in the mild to moderate continuum, TBI represents invisible wounds, as real as missing a limb but with no obvious damage to visibly "explain" the notable impairments. Additionally, recent studies highlight that TBI and PTSD co-occur in those returning from military combat deployments. As a result, research on the

association and interplay between these two disorders is increasing. The presence of TBI also doubled the risk for PTSD, and, interestingly, the strongest factor associated with persistent mild TBI symptoms was PTSD (Stein & McAllister, 2009). The previously cited RAND study found that forty-four percent of U.S. soldiers returning from the Iraq war who reported a loss of consciousness (a TBI symptom) also met criteria for PTSD.

Twenty percent of combat-exposed veterans endorse symptoms consistent with PTSD, depression, or other mental health problems (United States Department of Defense, 2006). PTSD affects relationships and families, including the relationships between spouses and the psychological adjustment and well-being of their children. Research has identified PTSD as mediating the effect of veterans' combat experience on the family (Gavaloski & Lyons, 2004). The core symptoms of this disorder—reexperiencing, avoidance, and hyperarousal—significantly and deleteriously affect interpersonal relationships.

Numbing and arousal symptoms in service members have been found to be especially predictive of family distress (Riggs, Byrne, Weathers, & Litz, 1998). The crucial role that effective emotional expression plays in developing and maintaining close and intimate relationships has long been emphasized. The impact of its absence is consistent with the general literature on marital and couples' functioning, which links the ability to engage in communication as integral to overall satisfaction with a relationship.

Constricted intimacy and expressiveness, limited emotional sharing, and lack of self-disclosure add to marital discord and thwart full integration into the family structure. PTSD-related avoidance behaviors spur withdrawal and isolation, and can induce the serious, functional loss of a parent and spouse from everyday family life, precluding communication and interfering with conflict resolution. The veterans' drive to avoid irritating stimuli is confusing and draining for

the family. Even normal developmental tensions and strains within the family can be experienced by the PTSD-impacted veteran as intolerable. These interpersonal impairments may directly interrupt the development of positive spousal and parent-child relationships.

Previous study of other traumatized populations—such as Holocaust survivors' families—has conceptualized the negative impact of an individual's traumatic stress on family members and close others as "secondary traumatization" (Figley, 1988). This phrase generally refers to the distress induced by being in close proximity with individuals who have been traumatized. Researchers have generally concluded that there is clear and consistent evidence for an intergenerational transmission of trauma to war veterans' children (Rosenheck & Fontana, 1998). Returning service member will also face the personal challenge of incorporating what they have done, learned, and seen in combat into their civilian lives. There is no "un-boot camp" or mechanism that exists to purposively reverse these influences and support reintegration.

For those injured and medically separated from the military, this can result in the loss of a way of life and income, including not being able to secure a pension if their time in service was not of sufficient length. For reservists, many will have lost both their residences and employment. Financial problems are replete. The Iraq and Afghanistan Veterans of America (IAVA, 2009) has noted that:

[B]etween the often-difficult transition to civilian life and the struggling American economy, hundreds of thousands of new veterans are facing an uncertain economic future. Already, among Iraq and Afghanistan-era veterans of the active-duty military, the unemployment rate was over 8 percent in 2007, which may be as much as 2 percent higher than their civilian peers. More than 40 percent of Guardsmen and Reservists lose income when they are mobilized . . . Veterans are

dramatically overrepresented in the homeless population . . . While they make up one tenth of the adult population, they are about one third of the adult homeless population.

There are also intangible losses that must be faced upon return. Less obvious, but no less real, these may include loss of a sense of personal invulnerability, self-esteem, or identity, as well as a loss of trust in God or protective powers and the loss that stems from the separation from comrades and an important war mission.

As part of the transition home, service members also experience a disruption in their existing social support systems when they leave behind those comrades whom they have relied upon the most during their military service for psychological strength. At this time of transition, when they need positive, strong social networks, they may be particularly vulnerable because these supports are gone and new ones have yet to be established. Given the months of separation from friends, family, spouse, children, and co-workers, a certain level of normative estrangement can be expected upon return. With the combination of other influences (e.g., PTSD, unemployment, marital discord, moral injury, etc.), disillusionment may set in and re-engagement in civilian life can be severely hampered.

IX. Combat PTSD and the Legal System

In this section, combat veterans who have problems with the law and their resulting intertwinement with the criminal justice system will now be briefly considered, although it is beyond the scope of this Article to provide a related in-depth psycho-legal discussion.

PTSD is mistakenly seen at times as a universally debilitating condition where consciousness and one's control over one's behavior is destroyed. Along these lines, the role of dissociation has frequently been cited and studied in efforts to explain the behavior of combat veterans accused of criminal acts

(McSherry, 1998; 2003). Dissociation refers to a disconnection or splitting in awareness. Not well understood, it is viewed by some as related to memory processing, while others perceive it as a psychological defensive functioning (McCann & Pearlman, 1990).

Some theorists believe that dissociation exists on a continuum (McLeod, Byrne, & Aitken, 2004). Whereas it is generally normative (e.g., being unable to recall your routine drive to work), it can become pathological under some circumstances (e.g., losing remembrance of significant periods of time associated with important events).

Though dissociative reactions and PTSD are often linked within the legal system, dissociation is only one potential symptom of this disorder and has not been considered one of the core cluster areas. As noted earlier, dissociation has only now been proposed to be listed as a symptom of PTSD (as part of Criterion B, the cluster area of intrusion reactions) in the upcoming DSM-V. Relatedly, flashbacks, an example of a PTSD-related dissociative reaction, are a relatively rare phenomena. In a 2007 comprehensive review of dissociation, Australian psychologist and PTSD scholar Richard Bryant noted that most of those individuals diagnosed with PTSD did not report significant dissociative reactions. He also underscored that dissociation is not a useful explanatory construct in understanding the mechanisms of PTSD. Dissociation is neither a precursor for the development of PTSD, nor a specific predictor for this disorder, even though it can be a prominent symptom for a small subset of those with the disorder (Waelde, Silvern, & Fairbank, 2005). As a result, theorists have proposed that it is only individuals who already possess dissociative tendencies who may respond to trauma exposure with dissociative reactions.

Alternatively, the essential PTSD core cluster area of hyperarousal—and its accompanying symptoms—does stem from an overtaxed and dysregulated nervous system. This essentially biologically based hyperarousal contributes to difficulty in evaluating external

cues and can mobilize *inappropriate* levels of physiological arousal in response to those cues. For example, hypervigilance is a symptom of hyperarousal in which intense threat scanning is maintained, even when not needed. It leads to an inability to discriminate genuine threats to safety and leads to misappraisals regarding one's exposure to danger. Current reality and the appropriate response to it are thereby distorted. As a result, situations that are not dangerous may be perceived as such with ensuing disproportionate—and often aggressive—behaviors. One widely publicized illustration of this would be that of returning OEF/OIF combat veterans having problems driving stateside given their exposure to improvised explosive devices (IEDs) that were hidden in the roads in Iraq and Afghanistan. When home, they sometimes drive too fast, aggressively, and tactically to avoid danger, with cases of such behavior having led to public safety concerns about veterans' "road rage."

The case can be made that individuals with military training, combat exposure, and ensuing PTSD may find it even more difficult to engage in an accurate appraisal of danger. Training for combat increases reliance on muscle memory or automatic actions in times of perceived threat, training that was provided initially by the military to help soldiers stay alive. But the physiological sensitivity that results from a chronically disordered pattern of arousal as is found in PTSD can set the stage for a quicksilver reactivity that leads to actions in a civilian setting that have criminal justice implications.

Consequently, such impairments can result in a returning veteran running afoul of the criminal justice system. To the extent that PTSD or related disorders have undercut a criminal defendant's free will or resulted in a failure to accurately appraise surrounding circumstances, the defendant's diagnosis may provide grounds for a "mental status defense," such as insanity, a lack of mens rea, or self-defense, or be viewed as a mitigating factor to be taken into account at sentencing

(Hafemeister & Stockey, 2010). Indeed, in a literature review, Pitman, Sparr, Saunders, and McFarlane (1996) found that a legal defense using PTSD tends to be more likely to be accepted if the offense is not premeditated or planned and is somehow reminiscent of the original traumatic stressor or its context.

In another vein, Sparr (1996) and Friel, White, and Hull (2008) suggested that there are a variety of possibly interconnecting elements resulting from war experiences that can help explain subsequent criminal conduct. The following were suggested:

- An attempt to be punished so as to overcome feelings of guilt about real or imagined moral transgressions;
- Sensation seeking—the repetitive pursuit of dangerous or risky behavior reflecting an addiction to combat violence that is perhaps secondary to chronic PTSD (i.e., a crime is committed while attempting to recreate excitement);
- Substance abuse to numb psychic pain (including PTSD-based psychic pain) and hyperarousal symptoms, but which also acts as a disinhibitor, leading to criminal behaviors; and
- Dissociative states, as discussed above, including altered states of consciousness (e.g., PTSD flashbacks), where a veteran commits a crime “automatically” or in the course of reliving a previously experienced traumatic event while unaware of the actual impact of his or her current actions.

Similarly, in a 2006 article on post-deployment violence and anti-social behavior, forensic psychiatrists David Benedek and Thomas Grieger noted that because war zone exposures are linked to negative emotional and behavioral consequences, concerns exist that the violent and aggressive behavior demonstrated in the combat zone will persist upon homecoming. There is indeed research that suggests that veterans with combat PTSD present with more anger, hostility, and

impulsivity than those not exposed to combat (Chemtob, Novaco, Hamada, Gross, & Smith, 1997; Lasko, Gurvots, Kuhne, & Orr, 1994). This has the *potential*, in turn, to translate into criminal behavior on occasion.

Though current research on the OEF/OIF veteran is being generated, most post-deployment violence and antisocial behavior studies are of returnees from the Vietnam War. These studies have demonstrated correlations between warzone exposures, PTSD, and post-deployment violence in subpopulations of these veterans. Benedek and Grieger (2006) write:

As deployments and homecomings are ongoing, any analyses of the extent to which this generation of returning members of the armed forces engage in violent or otherwise antisocial behavior are now only preliminary. The extent to which the studies of postdeployment violence [by prior generations] can be generalizable to the current population of returning volunteer force veterans (including larger percentages of women, reservists, and national guardsmen) is unclear. However, these studies suggest that, particularly in the population of veterans either actively seeking treatment or coming to clinical attention, antisocial behavior will be an issue of concern. (p. 55)

They ascertain, based on existing research, that there is a significantly larger veteran population beyond those diagnosed with combat PTSD who will demonstrate aggressive and other antisocial behaviors. In and of itself, however, the presence of combat PTSD is not a hallmark of violence and antisocial tendencies.

The relationship between PTSD and violence has been hard to discern. Some researchers have speculated that the increased anger sometimes found in PTSD sufferers may be fueled by core symptoms of the disorder. That is, cumulative sleep disturbance, irritability, and hypervigilance may also contribute to anger and aggressive acting out.

At the same time, the commonly found co-morbid disorders that often present with PTSD, particularly depression and substance misuse, also have an established relationship with aggression. This complicates the understanding of how PTSD and aggression may be linked. Not surprisingly, Friel, White, and Hull (2008) concluded that it is currently difficult to prove that there is a direct link between aggressive behavior and combat PTSD.

As follows, Canadian psychologist Sonia Grover (2007) objected to the successful use of a PTSD defense by a war veteran who had committed a sexual assault, writing:

It is counterproductive to society to create [the] entitlement to commit violence via the social definition of PTSD and what it supposedly might entail in terms of consequences . . . It is not helpful, then, when the courts—without scientific basis—reify PTSD as a causative factor that dictates and explicates choices that involve the violation of another's fundamental human rights. (p. 9)

Nevertheless, in 2008, the New York Times ran a series of articles by Deborah Sontag and Lizette Alvarez entitled “War Torn” (New York Times, 2008). This series focused on OEF/OIF veterans who had been convicted of probably the most serious of offenses after returning from combat duty—committing murder. Their investigation yielded 121 cases in which combat trauma and the stressors of deployment in combination with substance abuse, family discord, and other problems “set the stage for [tragedies] that [were] part destruction, part self-destruction.” In many cases, a connection to combat service was overt, while in others it merely cast a lingering shadow over the events, raising difficult questions as “offenders’ relatives struggle[d] to understand how a strait-laced teenager or family man or wounded veteran ended up behind bars—or dead.”

These articles, however, sensitively highlighted the different perspectives

regarding these actions. While interviewing service members who committed these offenses to document the extenuating circumstances of their criminal activities, family members of victims were also asked to describe their anguish in seeing their loved ones seemingly forgotten as a result of a shift of focus to the war returnee-perpetrator as the “new” victim. These articles addressed the thorny—and emotional—decisions about criminal responsibility and sentencing faced by judges and juries, as well as the cost of war on the homefront.

For example, the following letter was presented in court on behalf of a former Marine who had killed another local young man in their small town in Nebraska. It was written by the incarcerated Marine’s platoon leader. It protested the length of the sentence (21 years) and pleaded that this Marine be transferred to a medical facility for treatment of his combat trauma (New York Times, 2008, January 13, 2008):

Seth has been asked and required to do very violent things in defense of his country . . . He spent the majority of 2003 to 2005 in Iraq solving very dangerous problems by using violence and the threat of violence as his main tools. He was congratulated and given awards for these actions. This builds in a person the propensity to deal with life’s problems through violence and the threat of violence. I believe this might explain in some way why he reacted the way that he did that night in Nebraska. . . . I’m not trying to explain away Seth’s actions, but I think he is a special case and he needs to be taken care of by our judicial system and our medical system.

This letter’s poignancy is increased by the fact that its writer-advocate died in the line of duty several months afterwards in an I.E.D. attack in Baghdad.

It serves to spotlight the heart of the matter at hand: how do we handle our returning

warriors who have subsequently committed a crime? Should leniency be granted to those who are charged with crimes? And, if so, which crimes should be afforded leniency and under what circumstances?

In an attempt to address the issues of veterans who become embroiled in the criminal justice system, and who have not committed the more serious offenses, different states have launched Veterans Treatment Courts. They are aimed at helping veterans with nonviolent felonies and misdemeanor offenses avoid jail time and are often limited exclusively to combat veterans. They are a combination of mental health and substance abuse courts in that they accept those with mental health diagnoses (including that of PTSD and TBI), substance abuse problems, or both. Programs are tailored for each defendant based on their particular situation and coordinated to address the multiple problems often faced by returning service members ranging from homelessness, to unemployment, to securing evidence-based clinical treatment. In a targeted effort to engage a group that is known to be reluctant to seek help, veterans in these programs are assigned a peer-mentor who is either a veteran or an active duty service member. This assignment of a “battle-buddy” is done to reduce stigma, increase compliance, and provide the support of someone who has gone through a similar combat experience.

Veterans Treatment Courts view veterans as a specialized population with unique circumstances. As such, they require judges, prosecutors, and defense attorneys to learn more about psychological aspects and interventions tailored to veterans presenting with PTSD and other post-deployment problems. As Seamone (2009) writes:

The attorney must have independent knowledge of [the] scientific principles [of PTSD] and the ability to effectively incorporate them in legal analysis. Combat veterans with PTSD who find themselves in a criminal defense attorney or a family law attorney’s office are usually

experiencing the direct results of their symptoms. They come to attorneys for advice, guidance, and solutions to very real and immediate problems. The ramifications of their legal problems may have lifetime or life-ending implications. In many cases, such as the common scenario where a veteran is reluctant to seek help, the attorney’s office is the frontline in the fight for effective representation. (pp. 183-184)

Veteran treatment courts appear to acknowledge upfront the potential negative impact of combat. Research on their methods and outcomes will provide valuable information for both criminal justice and mental health professionals.

X. Conclusions

Returning military personnel face a significantly higher risk of experiencing a mental disorder than the general population. One such disorder that is receiving increasing attention is PTSD. Often tied to a military context, it has been used to encompass the broad range of post-deployment reintegration, adjustment, and reunion issues faced by returning war veterans. Though there are recommended treatments for PTSD, the evidence base supporting their use in treating veterans is in its early stages. Furthermore, outside of the VA, these treatments do not appear to be readily found within the clinical community at large. Hence, there is a divide between best clinical practice and the availability of evidence-based treatments for veterans in the community who do not wish to go to a VA.

At the same time, war returnees face a number of psychosocial stressors and may also have post-deployment emotional and psychological reactions (such as the previously described “moral injury”) that are not best captured by the PTSD diagnosis or even a subthreshold version and have no designated treatment regimens. It is essential to look at each returning member of service as an individual and to

avoid sweeping generalization or assumptions about experiences, motivation, and mental states (Gaughwin, 2005). One size does not fit all: a case by case approach is key. It is important to examine “functioning” objectively as if looking at the returning service member in a three-way mirror that captures the person before, during, and after exposure to military service and combat. In assessing PTSD, it is important to use objective state of the art assessment tools to establish an accurate diagnosis and severity level of the disorder. In crafting responses to these individuals, it should be noted that post-deployment resources and additional stressors matter significantly in shaping a successful or poor adjustment, and they should be duly noted in understanding related behavior. It is also imperative to assess the availability of help and the efforts made to access this help by the war returnee and those around him or her, as well as what barriers hindered these efforts.

Written for clinicians and those in the legal system who are dealing with returning service members, this Article has provided an overview of current, critical issues in the diagnosis, assessment, and treatment of combat related post-traumatic stress disorder (PTSD). Significant deployment cycle stressors, as well as the unique nature of combat, have also been presented. Hopefully, this information will serve to provide a context for attempting to understand the actions of those returning from warzone deployments who encounter problems with the law.

Perhaps there is a parallel process at work here. Those coming home from war’s frontlines will be faced with integrating experiences that only a select few can fully comprehend and manage. In their own fashion, those in the criminal justice system whose task is to respond to combat returnees who have committed a criminal offense must also grapple with battlefield trauma and its effects in striving to reach just and fair verdicts that appropriately reflect the toll of war.

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