

Collective Reckoning with the Post-9/11 Wars on a Colorado Homefront

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At a recent panel discussion convened in Colorado Springs by activist group Citizen Soldier,³ Dolores Vargas, the mid-thirties wife of an infantry staff sergeant, spoke to a room of veterans, family members, service providers, and activists. She began in a quiet, calm voice, thanking everyone for showing their support and giving her the opportunity to “bring up awareness of our real lives, behind closed doors.” Her voice clenched with emotion and she paused, collecting herself. “Sorry, I’m trying not to get emotional.”

Her husband joined the army to pursue his dream of becoming a command sergeant major. His first deployment was to Iraq, with a unit that would stand out for post deployment troubles. “You know, a lot of my husband’s soldiers are in jail...There’s a lot of murders, a lot of domestic violence. A lot of them are part of his unit.” After that first deployment, she said, her husband self-medicated with alcohol. During his second tour to Iraq in 2006, he suffered a TBI (traumatic brain injury) following an IED (improvised explosive device) explosion. It was following this deployment that Dolores noticed significant changes in his behavior. She urged him to seek help at Fort Carson, only to be turned away by an army doctor who said, “There’s nothing wrong with you. You’re faking it.” Dolores went to see another physician who agreed to diagnose her husband with PTSD [post-traumatic stress disorder] and put through papers for a medical discharge. “How am I supposed to help him get to where he was before without any help, without any knowledge? You know the military didn’t tell us about PTSD. They didn’t tell us about traumatic brain injury. They didn’t tell us that they were going to come back different.” Dolores begins to cry. She says she doesn’t know how to answer her children when they say, “I want my old daddy back.”

In the six years since her husband’s return she has quit her job to provide and advocate for his care. Dolores’s husband still feels responsible for helping soldiers from his unit who are suffering from PTSD and other effects of the war. But Dolores is clear whose responsibility this support work should be. As we leave the auditorium, Dolores’s refrain, “It’s not ok,” echoes in the room.

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³ Citizen Soldier is an activist group with a mission “to challenge US militarism.” <http://www.citizen-soldier.org/> [accessed July 31, 2013].

Dolores's story moves us behind the public stage where the President pins a medal on a soldier's chest, the media tells of a soldier who has overcome grievous wounds, and the veteran is showcased confidently translating her military skills to a civilian job. Dolores opens the "closed door" to reveal the domestic backdrop of the United States "making war" for well over a decade.⁴

Those who have borne the many costs of the post-9/11 wars at home often remain unseen and unrecognized. There are spouses who have held together homes and families, anxiously awaiting their partners' return only to find they no longer recognize the person who has come home. There are parents who must care for adult children grown unreachable, lost in sorrows, traumas, and persistent feelings of anger, shame or guilt, fearful that their child is at risk for suicide. There are toddlers who act out and teenagers whose schoolwork suffers when their parents deploy. There are soldiers and veterans who self-medicate with drugs and alcohol and have trouble holding jobs, whose marriages dissolve, and who often end up living on the streets. Finally, there are communities and institutions – schools, healthcare providers, and numerous governmental organs and nonprofits – who must shape their lives and work to respond to the ever-mounting new challenges returning veterans present.

While the majority of veterans return home without major injuries, physical or psychological, and adjust well to civilian life, many still harbor doubts about what they did, what they were asked to do, and whether the costs were worth the price. Our public images exclude the thousands of combatants and civilians injured and killed in Afghanistan and elsewhere who also carry scars, both mental and physical, from the war. Public discourses fail to convey the social costs both to the US, of a citizenry weary of war and yet largely disconnected from the less than 1 percent of the population directly engaged in fighting, and to Afghanistan, of an economy and infrastructure in shambles after over thirty years of continuous conflict. Other papers in this series address the costs to Afghans; here we draw on five years of fieldwork to portray how one US community shoulders the costs borne at home.

Post-traumatic stress disorder (PTSD) has emerged as a primary, if not *the* signature, injury of the post-9/11 wars. Estimates of the prevalence of combat-related PTSD in veterans of the Iraq and Afghanistan wars range from 2–17 percent.⁵ The most recent quarterly report on service utilization from the Veterans Administration (VA) shows that 30% of veterans of the post-9/11 wars who have received care through the VA since 2002 have had a diagnosis of PTSD.^{6,7} The most

⁴ MacLeish, Kenneth. (2013). *Making War at Fort Hood*. Princeton: Princeton University Press.

⁵ Richardson, Lisa K., B. Christopher Frueh, and Ronald Acierno. (2010). "Prevalence Estimate of Combat-Related PTSD: A Critical Review." *The Australian and New Zealand Journal of Psychiatry* 44(1), 4–19.

⁶ Estimated prevalence rates of PTSD among veterans are controversial. For a critical review of epidemiological studies see Richardson, Frueh, and Acierno

definitive study of rates of PTSD to date reveals that, when combined with the incidence of traumatic brain injury and major depression, approximately one-third of veterans of the post-9/11 wars return with a psychological injury, with a significant proportion suffering more than one.⁸ In contrast, researchers estimate the prevalence of PTSD among service members in the UK one year following deployment at 4 percent.⁹ Why are rates of PTSD so much higher among US veterans and why has PTSD become the predominant symbol of the suffering and costs borne by US military personnel and their families at this particular historical moment?

Part of the answer lies in the work Americans expect PTSD to do in identifying, understanding, and compensating for the costs of the post-9/11 wars. Although PTSD is a diagnosis and not actually capable of “doing work,” many of the people we interviewed gave it power and agency. PTSD may cause soldiers to confuse their spouses with the enemy and attack their spouses, drive soldiers to alcohol and drugs to alleviate symptoms, and help soldiers merit compensation as a wound of war. Journalists invoke PTSD to explain murder, suicide, domestic violence, reckless driving, substance use, and other distress among veterans. All too often PTSD is conflated with the myriad reintegration issues military personnel face when returning from multiple deployments or leaving military service, with the effects of war on families and communities, and with the disengagement of most US citizens from their military forces. For medical anthropologist Erin Finley, many veterans organizations and advocates see PTSD as “one shining fragment of the wrongs that veterans have been done by the military.”¹⁰

Though the medical diagnosis of PTSD was a critical step in public acceptance of the effects of war on soldiers’ mental health, medicalization is a double-edged sword. By defining soldiers’ responses to war as responses to trauma, much as fever is a response to infections, we deny soldiers both responsibility and accountability

(2010). The VA report only includes veterans who were eligible for and sought care at a VA facility. This is not a population-based prevalence rate and should not be assumed to apply to the total population of veterans.

⁷ EPPHO, Department of Veterans Affairs. (2014). “Report on VA Facility Specific Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn Veterans Coded with Potential or Provisional PTSD, from 1st Qtr FY 2002 through 2nd Qtr FY 2014.” Washington, DC: Department of Veterans Affairs. Retrieved from <http://www.publichealth.va.gov/docs/epidemiology/ptsd-report-fy2014-qtr2.pdf>.

⁸ Ibid.; Tanielian, Terri, and Lisa H. Jaycox (Eds). (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica: RAND Corporation.

⁹ Hotopf, M., L. Hull, N. T. Fear, T. Browne, O. Horn, A. Iversen, M. Jones, D. Murphy, D. Bland, M. Earnshaw, N. Greenberg, J. H. Hughes, A. R. Tate, C. Dandeker, R. Rona, and S. Wessely. (2006). “The Health of UK Military Personnel Who Deployed to the 2003 Iraq War: A Cohort Study. *Lancet* 367(9524), 1731– 1741.

¹⁰ Finley, Erin. (2011). *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan*. Ithaca, NY: Cornell University Press. (p. 9).

for their wartime actions and failures to act, good or bad, courageous or cowardly. Creating a new classification of “moral injury” may help us recognize the moral dimension of soldiers’ suffering and difficulties during reintegration, but such a classification also oversimplifies. We must look beyond PTSD, beyond the myth of the individual soldier as hero, to recontextualize the wars and their consequences as part of the global whole in which we all play a part. But our ability to ask and answer these questions is hampered by the structure of the military and the history of past conflicts.

A narrow focus on PTSD, or even the more nuanced “moral injury,” does not capture the structural and historical problems that alienate returning service members and their families. These problems include the army’s campaign to destigmatize PTSD and encourage soldiers who are experiencing difficulties to seek help while simultaneously giving less than honorable discharges to soldiers whose “problematic” behavior might result from PTSD or TBI, thus precluding them from receiving benefits and compensation.¹¹ Problems include the military’s arbitrary red tape blocking civilian access to this population, even when providers and volunteers step forward to serve veterans. Problems also include offloading care work onto families without compensating them.¹² And nothing captures reasons for alienation more sharply than recent scandals at the Veterans Administration, as veterans wait months to access care, while books are systematically cooked to hide such problems.

We argue that recognizing and treating PTSD is a necessary, but not sufficient, response to soldiers’ and communities’ efforts to come back and heal from war. The reductive focus on PTSD in both popular and scholarly literature needs decentering. A narrow focus on PTSD too often sidelines attention to other injuries (particularly traumatic brain injuries, in addition to depression and substance abuse); to soldiers’ resistance to medical diagnoses as the sole reason that reintegration and recovery are often difficult. Exclusive attention to diagnosing and treating PTSD leaves out the generalized stress and *distress* that all those living closest to war’s inherent stresses and horrors experience. How do we undertake healing the social fields, both domestic and international, damaged through failed efforts to affect the course of the war, or through maintaining distance from war even as it profoundly affects local communities? It is, moreover, critical to separate PTSD and the treatment of trauma from reintegration issues that soldiers might experience, whether or not they have PTSD.

PTSD Defined

¹¹ Philipps, Dave. (2013). “Disposable: Surge in Discharges Includes Wounded Soldiers.” *The Gazette*. Retrieved from <http://cdn.csgazette.biz/soldiers/day1.html>.

¹² Howell, Alison, and Zoë Wool. (2011). “The War Comes Home: The Toll of War and the Shifting Burden of Care.” *Costs of War*. Retrieved August 30, 2013 from http://www.academia.edu/3363619/The_War_Comes_Home_The_Toll_of_War_and_the_Shifting_Burden_of_Care.

PTSD is defined by specific symptoms or behaviors following exposure to a traumatic event or events, including recurrent, involuntary, and intrusive memories of the traumatic event, recurrent nightmares, flashbacks in which it appears that the trauma is happening again, or psychological distress or physical reactions such as rapid heart rate. These symptoms last for more than one month and interfere with the person's ability to function in important areas of his or her life. Traumatic events include "actual or threatened death, serious injury, or sexual violence." The afflicted can directly experience the event themselves, witness it happening to others, learn about it occurring to a close family member or friend, or be exposed to extreme or repeated details about it as, for example, in the case of "first responders collecting human remains [or] police officers exposed to details of child abuse."¹³

Although most psychiatrists and laypersons view PTSD as a universal biological response to the traumatic events of war, how those responses are interpreted, explained, diagnosed, and treated varies significantly across cultures and through time. The American Psychiatric Association adopted PTSD as an official diagnosis in 1980 in response to activism by Vietnam veterans and victims of sexual assault and abuse. As noted above, the prevalence of PTSD in military personnel from the UK who served in Iraq is four to five times lower than among US military personnel. An American psychiatrist studying the effects of the Lebanese civil war on civilians found little evidence of "psychic traumatization" that would be diagnosed as PTSD.¹⁴ This is not to suggest that the Lebanese did not suffer from the civil war, but that how they expressed their suffering did not necessarily fit the constellation of symptoms defined as PTSD. Many medical anthropologists question the validity of applying PTSD cross-culturally.¹⁵

Thus to understand why PTSD has become such a prominent symbol of the post-9/11 wars requires a culturally informed analysis. PTSD is now applied in everyday conversations in the United States to explain anxiety or worry following an upsetting experience. PTSD's wide public acceptance arises from two converging

¹³ American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association. (309.81 [F43.10]).

¹⁴ Pattison, E. Mansell. (1984). "War and Mental Health in Lebanon." *Journal of Operational Psychiatry* 15, 31-38.

¹⁵ Bracken, Patrick J. (2001). "Post-modernity and Post-traumatic Stress Disorder." *Social Science & Medicine* 53(6), 733-743.; Bracken, Patrick J., Joan E. Giller, and Derek Summerfield. (1995). "Psychological Responses to War and Atrocity: The Limitations of Current Concepts." *Social Science & Medicine* 40(8), 1073-1082.; Breslau, Joshua. (2004). "Cultures of Trauma: Anthropological Views of Posttraumatic Stress Disorder in International Health. *Culture, Medicine and Psychiatry* 28, 113-126.; Hinton, Devon E., and Roberto Lewis-Fernández. (2010). "The Cross-Cultural Validity of Posttraumatic Stress Disorder: Implications for DSM-5." *Depression and Anxiety* 28(9), 1-19.

cultural trends. First is the trend to explain human behavior in individual, psychological terms. Second is the establishment of “a commonplace of the contemporary world, a shared truth,” that painful events generate stress and leave scars on the mind as well as the body.¹⁶ As a consequence, since its adoption in 1980, the definition and application of PTSD have undergone significant “bracket creep.”¹⁷ In the original definition, the event had to threaten the person’s life directly or someone else physically present and close. The current definition allows for hearing about a life-threatening event happening to someone else. Americans use PTSD to explain anxiety and worry from a variety of non life threatening, upsetting events, or to explain the stress of caring for people who have PTSD, characterized as “vicarious trauma” or “secondary PTSD,” superseding older terms like “burnout” and “compassion fatigue.”

The lack of specificity around PTSD’s causes and symptoms renders the diagnosis an ideal way to express a variety of sources of anxiety and suffering, what medical anthropologists call an “idiom of distress,” the “particular ways in which members of sociocultural groups convey affliction.”¹⁸ In other words, individuals express painful feelings in culturally accepted ways using culturally accepted terms. The terms bring together a set of physical symptoms, behaviors, and emotional states into a syndrome that might, if severe enough, also correspond to recognized and legitimated medical or psychiatric disorders. Once established, much like a medical diagnosis, these terms are taken for granted, “so embedded in everyday interactions that they are considered ‘common sense.’”¹⁹ In addition to PTSD, “acting-out behaviors such as drinking alcohol and getting in disputes” are other idioms of distress that may signal underlying clinical conditions such as PTSD, TBI, or depression in US veterans.²⁰

Establishing PTSD as a medical diagnosis was a critical step in conferring legitimacy and obtaining compensation and much-needed mental health and social services for veterans. Soldiers and veterans diagnosed with PTSD should receive the most effective evidence-based treatments available and compensation for their injuries. But all too often, PTSD is conflated with the myriad issues military personnel face when returning from multiple deployments or leaving military

¹⁶ Fassin, Didier, and Richard Rechtman. (2009). *The Empire of Trauma: An Inquiry into the Condition of Victimhood*. Rachel Gomme, trans. Princeton and Oxford: Princeton University Press.

¹⁷ Dobbs, David. (2009, April). “The Post-Traumatic Stress Trap.” *Scientific American*. 64–69.

¹⁸ Nichter, Mark. (2010). “Idioms of Distress Revisited.” *Culture, Medicine and Psychiatry* 34(2), 401–16.

¹⁹ Hinton, Devon E., and Roberto Lewis-Fernández. (2010). “The Cross-Cultural Validity of Posttraumatic Stress Disorder: Implications for DSM-5.” *Depression and Anxiety* 28(9), 1–19.

²⁰ Ibid.

service, the effects of war on families and communities, and the disengagement of most US citizens from their military forces.

For many mental health providers, the diagnosis of PTSD is merely a beginning to the therapeutic process, one that confers legitimacy and secures payment for services. Diagnosing PTSD does not preclude these providers from exploring the many other issues that soldiers, veterans, and their families face, for example, by making referrals for employment counseling, assistance with applying for veterans benefits, reconnecting with community through arts or recreation, or going to school.

Medicalization, defining a set of symptoms or behaviors as a medical condition, is a complex process, fraught with contradictions; this is especially true for mental and behavioral conditions. The advantages of medicalization can be offset by ways in which a disease framework becomes problematic in understanding and responding to illness and suffering. Many soldiers prefer to think of PTSD as a normal reaction to an abnormal situation – in other words, something that anyone exposed to enough trauma might experience. While this should, in theory, remove much of the stigma of PTSD, for many active-duty soldiers the diagnosis is still highly stigmatized. Stigma comes from the definition of PTSD as a mental *disorder*, hence there is some effort among veterans to call it “post-traumatic stress.” PTSD also signals weakness: it suggests that a soldier is not able to cope with the stresses of combat and military service, cannot do her or his job, might let fellow soldiers down, and generally is unable to “suck it up and move on.” PTSD thus violates the warrior ethos drilled into new recruits, representing both illness and failure. As a consequence, many active-duty soldiers view those who claim to have PTSD with suspicion, questioning whether they are truly suffering or just trying to get out of a difficult and stressful situation or get compensation. The condition’s acceptance by the American Psychiatric Association confers legitimacy and should, again in theory, remove this doubt. Although the army has expended great effort in campaigns to reduce the stigma associated with getting help for mental injuries, the stigma persists. Many soldiers and veterans, reluctant to seek mental health services, self-medicate with drugs and alcohol. One soldier we interviewed told us about his buddy whose best friend was killed right in front of him. “Ever since then he’s been totally different. He’s had all sorts of run-ins with the law.” He added that his friend is now getting the attention he needs, “but it took him shooting a gun off in public for him to get the help.”

PTSD often co-occurs with depression and TBI, which receive much less attention. Any of these can lead to behaviors such as chronic lateness in reporting to work, missing appointments, or losing one’s temper. These behaviors are easily misinterpreted, especially away from combat zones, as misconduct. Misconduct is the most common reason for an other-than-honorable discharge, which precludes soldiers from receiving military and VA benefits. An investigative report by *The Gazette* in Colorado Springs documents the dramatic rise (67 percent) in discharges for misconduct in 2012 at the eight army posts where most combat units deployed

to Iraq and Afghanistan are stationed. “And soldiers with the most combat exposure are the hardest hit.”²¹

Beyond these unrecognized or misrecognized impacts of militarization and war, another issue that receives little attention in the media is the wear and tear on soldiers’ bodies from carrying up to 63 pounds of gear, excluding the weight of weapons, over difficult terrain, as part of their usual duties.²² Many soldiers leave the military addicted to pain medication or drinking heavily to dull their pain.

PTSD in these Wars

While PTSD can certainly amplify and complicate reintegration into civilian life on return, military personnel without mental injuries also confront a variety of challenges from multiple deployments. Of 1,853 veterans who served after 9/11 surveyed by Pew Research in 2011, 44 percent reported difficulty adjusting to civilian life.²³ Being a college graduate (all officers hold college degrees), understanding the military mission, and being religious were associated with easier re-entry to civilian life. In contrast, experiencing a traumatic event, being seriously injured, being married during service, serving in combat, serving after 9/11, and knowing someone who was injured or killed were associated with more difficulty re-entering civilian life. Many enlistees were not college-bound prior to enlistment, or enlisted as an alternative to college. Even though the post-9/11 GI bill supports higher education, soldiers’ time in military service means they fall behind their civilian peers of the same age in work experience and education. For those who entered the military from high school, leaving the military is the first time they must negotiate the civilian world as adults. In addition, a significant proportion joined the military to escape small towns with few economic prospects or neighborhoods where they were getting into trouble, places they may have little desire to return to.

This is the first protracted war fought without draftees, by an all-volunteer force (AVF). Some argue that the AVF has created a dangerous military-civilian divide, with less than one percent of the nation’s population serving in the armed forces while “the rest go to the mall,” as one angry parent of a wounded soldier observed.²⁴ Moreover, fighting prolonged campaigns on two fronts has meant heavy

²¹ Philipps, Dave. (2013). “Disposable: Surge in Discharges Includes Wounded Soldiers.” *The Gazette*. Retrieved from <http://cdn.csgazette.biz/soldiers/day1.html>.

²² MacLeish, Kenneth. (2013). *Making War at Fort Hood*. Princeton: Princeton University Press. (p. 63).

²³ Morin, Rich. (2011). “The Difficult Transition from Military to Civilian Life.” *Pew Research Social and Demographic Trends*. Retrieved May 19, 2014 from <http://www.pewsocialtrends.org/2011/12/08/the-difficult-transition-from-military-to-civilian-life/>.

²⁴ Schiff, Rebecca L. (2008). *The Military and Domestic Politics: A Concordance Theory of Civil-Military Relations*. New York: Routledge;

Feaver, Peter D. (2011). “The Right to be Right.” *International Security* 35(4), 93-94;

reliance on reserve and national guard troops and multiple deployments with dwell time (time between deployments) well below recommended levels. In addition, to compete with the civilian labor market for recruits and retain personnel, even in times of relative peace, leaders of the AVF have had to alter societal attitudes toward families of enlisted personnel and attend to family needs as a whole. Whereas during the Vietnam war most enlisted soldiers were young and unmarried, and the military discouraged enlisted personnel from marrying, today half (52 percent) of all army personnel, officers and enlisted, are married, and 47 percent have children, half of them under 7 years of age.²⁵ This means that family members outnumber service members, and are directly affected by multiple deployments and the absence of soldiers for days to years at a time. Although the steady, full-time pay and benefits from military service mean that many young people can marry at younger ages than their civilian counterparts, and military salaries for enlisted personnel correspond to the 90th percentile of civilian wages of similar age and education levels, this still may not always be enough to comfortably support a growing family.²⁶ Combined with inexperience in handling personal finances, this can lead to problems with debt and falling behind on car or house payments. Of military personnel surveyed by the Financial Industry Regulatory Authority in 2010, 25 percent had over \$10,000 in debt, over half made only minimal repayments in some months and 21 percent used high-cost payday or auto title loans.²⁷ Military spouse Theresa Thayer told us of the financial difficulty many families face in losing the \$150 to \$225 monthly “combat pay” when their soldiers come home.

see also Janowitz, Morris. (1960). *The Professional Soldier: A Social and Political Portrait*. Glencoe, IL: Free Press.

²⁵ Booth, Bradford, Mady Wechsler Segal, and D. Bruce Bell. (2007). *What We Know About Army Families: 2007 Update*. Washington, DC: Caliber and US Army.

²⁶ U.S. Department of Defense. (2012). “Report of the Eleventh Quadrennial Review of Military Compensation.” *Main Report*. Washington, DC: Department of Defense. In 2012, the Quadrennial Review of Military Compensation completed a comprehensive comparison of military and civilian compensation “which showed that military pay compares favorably to civilian earnings, for officers and enlisted personnel at all years of experience” (22). The study compared enlisted personnel to civilians with three different levels of education: high school graduates, some college, and associates degrees and compared officers to civilians with bachelors and graduate degrees (26). Military compensation includes basic pay, housing allowance, subsistence allowance, special and incentive pays, and tax advantage that accrues because housing and subsistence allowances are exempt from federal income tax.

²⁷ FINRA. (2010). “Financial Capability in the United States: Military Survey—Executive Summary.” Washington, DC: FINRA Investor Education Foundation. Retrieved May 19, 2014 from <http://www.finra.org/web/groups/foundation/@foundation/documents/foundation/p122257.pdf>.

Multiple deployments have kept military personnel and their families constantly readjusting roles in the family, patterns of communication, and routines. As soldier Kevin Windum told us, “You can’t just turn it off like a switch. You’re going out there every day, getting shot at, shooting at other people – then you come back, and it’s all calm and nice.” Spouses told us it was often easier for them to separate for significant deployment periods when they were arguing. As army wife J.J. Thomas told us, “And then all the problems that happen when the soldier comes home in that first two weeks. You have a lot of domestic violence issues... and a lot of marital problems because they come home and nobody knows how to interact with each other.” Sarah Jones, counselor at an agency that assists victims of domestic violence, noticed that domestic violence cases in units that had deployed to Afghanistan or Iraq doubled at 90 days after returning from a deployment. She added that although some incidents involved things like flashbacks to combat situations in which the soldier might confuse his wife with the enemy, for the most part combat stress and the means soldiers use to self-medicate – drugs and alcohol – amplified relationship problems that existed prior to deployment.

Reintegration can be a particularly difficult time in a marriage or romantic relationship as partners renegotiate domestic roles and reestablish intimacy at a time when soldiers, particularly those troubled by trauma and loss suffered in combat, may withdraw, seeming distant, or physically present but mentally and emotionally absent. Combat-related PTSD can stress intimate relationships still further, contributing to divorce, child abuse, and intimate partner violence.

The media has brought attention to the rising rate of suicides in military personnel. In 2008, the rate of suicide among military personnel, normally lower than in the civilian population, rose above the US national average. Suicide is “the third leading cause of death among the Army population.”²⁸ The Department of Defense report on suicide published in 2010 noted that the two stressors most strongly associated with military suicides are relationship difficulties (55.8% of cases) and work/life balance (57.4% of cases). Military deployments to a war zone inevitably stress families and disrupt work/life balance, even for those military personnel who do not experience PTSD or other mental health issues. As the Army’s report also notes, multiple deployments, insufficient dwell time between deployments, loss of combat pay when soldiers return home, and frequent moves and reassignments, have all contributed to the rising suicide rate. In addition, during the early years of the wars, the army issued waivers for recruits with histories of violence, substance use, and poor educational records, again, factors associated with higher rates of suicide and PTSD.²⁹ Added to this is a military environment, especially among young enlisted soldiers, that encourages alcohol and drug use as accepted ways of handling pain and loss and releasing tension.

²⁸ U.S. Army. (2010). *Health Promotion, Risk Reduction, and Suicide Prevention Report*. Washington, DC: Department of the Army. Retrieved May 19, 2014 from <http://csf2.army.mil/downloads/HP-RR-SPReport2010.pdf>.

²⁹ Ibid.

In his introduction to the suicide report, General Peter Chiarelli acknowledges the toll that an “unprecedented operational tempo for almost a decade” has taken on military personnel, pushing some soldiers “to their breaking point.” Yet the report’s recommendations to reduce suicide all focus on the individual soldier: reducing individual risk behaviors through resilience training, improving detection and treatment through increased mental health screening and services while deployed and at home, suicide awareness campaigns, and improving leadership – all instead of correcting the structural issues of a small fighting force stretched thin on two fronts.

PTSD's Effects on Families and Communities

Spouses and families often find it difficult to embrace the returning soldier when the family functioned well while the soldier was away, especially when families know soldiers would be soon leaving again for the next deployment. Long absences mean that everyone has undergone changes and had different experiences. As army spouse Theresa Thayer told us, “I’ve gotten a new husband three different times.” Perhaps surprisingly, it is often spouses and children who are most anxious as homecoming nears and who find the adjustment most difficult.³⁰ Whereas soldiers may feel they no longer have a place in the family, spouses (overwhelmingly wives) may be reluctant to give up control they have worked hard to achieve and adolescents may worry their parents will not recognize how much they have matured.

Deployments can be very stressful on spouses and children. Deployments of nine months or longer and more frequent deployments place female spouses at greater risk for depression, anxiety, and adjustment and sleep disorders.³¹ Young children with deployed parents see pediatricians more frequently for mental and behavioral health issues than those whose parents are not deployed.³² Older

³⁰ Booth, Bradford, Mady Wechsler Segal, and D. Bruce Bell. (2007). *What We Know About Army Families: 2007 Update*. Washington, DC: Caliber and US Army.

³¹ Mansfield, A. J., J.S. Kaufman, S.W. Marshall, B.N. Gaynes, J.P. Morrissey, and C.C. Engel. (2010). “Deployment and the Use of Mental Health Services among U.S. Army Wives.” *New England Journal of Medicine* 362(2), 101–109.; Sherman, Michelle, and Ursula Bowling. (2011). “Challenges and Opportunities for Intervening with Couples in the Aftermath of the Global War on Terrorism.” *Journal of Contemporary Psychotherapy* 41(4), 209–217.

³² Chartrand, Molinda M., Deborah A. Frank, Laura F. White, and Timothy R. Shope. (2008). “Effect of Parents’ Wartime Deployment on the Behavior of Young Children in Military Families.” *Archives of Pediatrics & Adolescent Medicine* 162(11), 1009–1014.;

Gorman, Gregory H., Matilda Eide, and Elizabeth Hisle-Gorman. (2010). “Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints.” *Pediatrics* 126(6), 1058–1066.

children and girls of all ages have more problems with school, family, and peer relationships,³³ and younger children and boys are at higher risk for depressive and behavioral symptoms.³⁴ Children of military parents may feel that they, too, have been enlisted, but with less agency. As novelist Pat Conroy noted about growing up as the child of a marine officer during the Vietnam era, “We spent our entire childhoods in the service of our country, and no one even knew we were there.”³⁵ Some researchers caution against pathologizing children of military families; nonetheless, they acknowledge the stress on children and non-deployed parents that come from long absences of parents or partners deployed to areas of danger.³⁶

Although more civilian spouses of service members work today than in the Vietnam era, and more are men, the behind-the-scenes work of supporting the families of deployed soldiers is still highly gendered as feminine work and goes largely unremunerated.³⁷ This work includes emotional, technical, and administrative tasks, and plain heavy lifting, with many shouldering these tasks for over a decade of war. The process is complex, as army wives who adopt these roles often find that the gender-stereotyped organization of this work may be “slightly archaic,” but nonetheless “works best,” as one wife told us. This unpaid support work provides wives with “a public arena in which to perform that work and be acknowledged for it.”³⁸ The “public” arena Gassman describes is public only within the world of the military that these wives have chosen as the place they look for recognition and status; military wives’ work remains largely invisible to the larger civilian community.

PTSD, Treatment, and Fickle Funding

³³ Chandra, Anita, Sandraluz Lara-Cinisomo, Lisa H. Jaycox, Terri Tanielian, Rachel M. Burns, Teague Ruder, and Bing Han. (2009). “Children on the Homefront: The Experience of Children from Military Families.” *Pediatrics* 125, 16–25.

³⁴ Cozza, Stephen J., Ryo S. Chun, and James A. Polo. (2005). “Military Families and Children during Operation Iraqi Freedom.” *Psychiatric Quarterly* 76(4), 371–378.

³⁵ Musil, Donna (Producer and Director). (2005). “Brats: Our Journey Home.” [Documentary]. Atlanta, GA: Brats without Borders.

³⁶ Kelley Michelle L., Lisa B. Finkel, and Jayne Ashby. (2003). “Geographic Mobility, Family, and Maternal Variables as Related to the Psychosocial Adjustment of Military Children.” *Military Medicine* 168(12), 1019–1024.;

Watanabe, Henry K., and Peter S. Jensen. (2000). “Young Children’s Adaptation to a Military Lifestyle.” In James A. Martin, Leora N. Rosen, and Linette R. Sparacino (Eds.), *The Military Family: A Practice Guide for Service Providers*. Westport, CT: Praeger.

³⁷ Karney, Benjamin R., and John S. Crown. (2007). *Families under Stress: An Assessment of Data, Theory, and Research on Marriage and Divorce in the Military*. Santa Monica, CA: RAND Corporation. (p. 20).

³⁸ Gassmann, Jaime Nicole Noble. (2010). *Patrolling the Homefront: The Emotional Labor of Army Wives Volunteering in Family Readiness Groups* (Doctoral dissertation). Available from University of Kansas. (p. 27, 81).

Colorado Springs, in addition to housing approximately 70,000 active-duty military personnel, is also home to one of the largest populations of military retirees in the country, many of whom serve on boards of directors and as staff of local nonprofit agencies. It is a community, as soldier Chris Stimpert told us, where “everyone makes military [personnel] feel welcome and supported.” Community residents, both former military and civilian, have come forward during the post-9/11 wars to offer their support and help in serving active-duty personnel, veterans, and their families.

In 2006, a veteran and retired service member who worked for the army as a civilian created a network of organizations serving injured military personnel, veterans, and their families in the region. The network includes dozens of participating organizations ranging from mental health providers, US Paralympics, low-cost legal services, granting agencies that fund programs, and building contractors who adapt houses for disabled soldiers, to programs that offer free hot-air balloon rides, rounds at a local resort’s golf course, or river rafting trips. An arts organization based in nearby Manitou Springs works with one of the elementary schools at Fort Carson each year on an art project that brings together students and their military-affiliated parents to build giant puppets that fill the school’s central lobby, based on a character from a children’s book that the students select. Pikes Peak Community College, where approximately one-quarter of students are active-duty military, military dependents, or veterans, offers numerous support services to ensure student success, as does the University of Colorado at Colorado Springs. Many of these programs focus directly on PTSD as shaping their rationales and missions, as well as making PTSD diagnosis a mandatory criterion for admission. One veteran peer mentor, for example, believes that “anybody that has been deployed more than one time has PTSD whether or not they have sought treatment or they believe they do,” precisely because this diagnosis makes veterans admissible to a special Veterans Trauma Court program that could benefit any veteran with legal trouble.

When we began our work in 2008, civilian therapists were eager to qualify for Tricare, the military’s health insurance program, so that they could treat active-duty soldiers and veterans. Yet many found that referrals from Fort Carson were a fickle spigot, with policies governing referrals to civilian providers changing whenever command changed, and the military concerned with regulating and maintaining the quality of care, thus wary of opening its doors too wide to civilians. Civilian mental health providers may not be trained in the newest, cutting edge developments in the treatment of PTSD, and they use a wider range of treatment modalities than therapists working within the armed services. Nor do civilian therapists share military commanders’ need to combine care for soldiers’ mental health with meeting boots-on-the-ground readiness requirements. During the post-9/11 wars, the Department of Defense and Veterans Administration have undertaken research to determine the efficacy and safety of current treatments for PTSD. The most promising evidence-based treatments for PTSD, those the Veterans

Administration endorses, eye movement desensitization and reprocessing (EMDR) and cognitive behavioral therapy, involve recall of traumatic events in supportive, structured therapy sessions to restructure how traumatized individuals understand and make sense of these events. Certain anti-depressants, selective serotonin reuptake inhibitors (SSRIs), have also proven effective in combination with cognitive behavioral therapies. A new generation of therapists at the Veterans Administration who are trained in and champion the superior efficacy of these treatments, going so far as to suggest the possibility of a cure for PTSD, often find themselves in conflict with an older generation of therapists who favor individual and group talk therapy with an orientation to long-term management of symptoms.³⁹ These treatments all focus on the individual and none mandate involvement of the family or community.

Responsibility and Moral Injury

War is a collective enterprise, declared by a nation's leaders, but fought by its citizens as volunteers or conscripts who wound and kill in the name of the state.⁴⁰ War's consequences are inherently social, including the isolation of soldiers who return home troubled by the questions their participating in war raises. Acknowledging this to some extent, media accounts are drawing increased attention to moral injuries, those things that soldiers witness, are asked to do, or do that call into question the collective values they ostensibly fight to protect and uphold.

The significance of such moral questioning was brought home to us relatively early in our project when we were asked to organize a panel to present our ongoing research as part of "Veterans Remember," an event organized by Vietnam veteran Joe Barrera to provide a "place of receptivity" where soldiers could exchange stories between "older guys," mostly Vietnam veterans, and recent veterans of the post-9/11 wars. In setting up the rules and guidelines for the event, Joe emphasized "the importance of a nonjudgmental, civilian audience." The event took place on Veteran's Day in 2010 on a college campus in the heart of Colorado Springs.

College student Joey Glick, who had been studying military chaplains and civilian churches' responses to soldiers' mental health problems, was halfway into his presentation when Quentin, a soldier who came as part of a local PTSD support group, raised his hand.

"I have a question for you, but I'm not sure if you can answer it for me," he asked as he gestured at the PowerPoint slide on the screen. "I'm listening to you say all this stuff about PTSD, and TBI, and the ABCs. But, can you tell me why we are in Afghanistan?"

³⁹ Finley, Erin. (2011). *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan*. Ithaca, NY: Cornell University Press.

⁴⁰ Scarry, Elaine. (1985). *The Body in Pain: The Making and Unmaking of the World*. New York: Oxford.

The question caught all of us off guard, for Quentin raised the very question we, as civilians, under Joe's guidelines, felt chastened not to ask. As Joey later wrote, "He was correct in expecting me to have difficulty responding to his question. I . . . have little confidence in my ability to give a meaningful response to such challenging questions of foreign relations." But Joey also felt unable to answer the question based on his conversations with chaplains and faith leaders. "Of the people who regularly interacted with soldiers, none of my informants saw a reason to engage political or moral questions when counseling soldiers or their families. Instead, time and time again, informants talked about the importance of disconnecting the innocent soldier from the complex politics of American foreign policy."

Quentin's question goes to the core of what the war in Afghanistan has cost soldiers, their families, civilians, and communities throughout the US. Although attention to the moral aspects of soldiers' experiences helps move us beyond a narrow focus on PTSD, such attention is limited as well, for it encapsulates suffering and keeps the emphasis on the individual soldier and his or her actions and away from the political and military leaders who ordered them into combat and the civilians, willingly or not, who stand behind them. Moral injury, moreover, does not capture the experiences of soldiers who feel their consciences are clear but whose spirits were nonetheless wounded by what they saw or did.

One of the "dirty little secrets" that Captain Dawn Weaver, a psychiatric nurse working in the emergency room at Fort Carson, learned in working with combat veterans from Afghanistan and Iraq was that the rules of engagement, designed to keep soldiers' actions with legal and moral bounds, contributed to them becoming "so primed to killing....they are in situations where they can't defend themselves sometimes, and that makes them—and I use this word carefully—that makes them absolutely crazy. It makes them insane: where they are getting shot at, they are getting fired upon, and their lives are at risk, and they cannot shoot back." But sometimes, of course, they do shoot back, among other responses. Returning to civilian life and recognizing what their "primal brain had them do...they find themselves absolutely reviled, repugnant. They can't tolerate themselves." But the most important secret, which Weaver called the "*coup de grâce*," is one that soldiers work up to talking about only slowly. "A lot of these guys have had to kill children. And by that I mean the insurgents have trained children to take weapons out on the street and point them at soldiers so that the soldiers will shoot them."⁴¹ Because they know that Americans will be forever damaged by that. These moral and spiritual injuries that that causes are exceedingly deep."

⁴¹ Little reliable research exists on the veracity or extent of children being used in this way. Mentions of such tactics are common, nonetheless, in US soldiers' spoken narratives, especially about Iraq, as well as in counterinsurgency training manuals (i.e., Kilcullen, D. (2006). Twenty-Eight Articles Fundamentals of Company-level Counterinsurgency. *Marine Corps Gazette*, 90(7), 50 (p. 33).)

All this means that for many soldiers we spoke with, being “thanked for their service” or celebrated as heroes upon their return to the US can be highly problematic. Unlike the mercenary, the soldier volunteers for military service, calling not upon market exchange of their labor for wages, but on a moral exchange between the soldier and the state. In exchange for the soldier’s willing sacrifice, the state promises him or her care in case of injury, and, in case of death, burial and support for his or her spouse and children. Perhaps most important, the state asks for the sacrifice in a just cause and true need. Thus the soldier becomes a “moral exemplar” and a hero. But what happens when events challenge just cause and true need? Former service member and anthropologist Andrew Bickford argues that heroism is “the balm we use to soothe the suffering of family and friends” left behind, but it is a shallow remedy that many “heroes” and their families reject.⁴² At a NATO summit held in Chicago in May 2012, 45 veterans of Iraq and Afghanistan threw back their medals from the Global War on Terror in protest. As one soldier said, “I will not continue to trade my humanity for false heroism.”⁴³ When we asked soldier Daniel Quest if being honored helps soldiers deal with PTSD, he replied, “Probably not. I don’t think it helped me. People just brought it up constantly, every day. I’d get pissed off. I’m a freaking hero because I was shooting 50-caliber rounds through families’ living rooms and shit. How does that make me a hero?”

Reckoning the Collective Costs of War

Civilians are hampered in responding to questions like those posed by Daniel Quest by what we call “post-Vietnam paralysis” in which critically engaging the war is equated with dishonoring soldiers. Assessing wars’ efficacy and costs is the work of US citizenry, whether through witnessing coffins coming home, recognizing the count of Afghan civilians and combatants killed and injured, or grasping how, after being at war for thirty years, so many Afghans face starvation, economic despair, and the highest rate of depression in the world (yet with only two trained psychiatrists).⁴⁴

We have argued that facing and accounting for the effects of war’s traumas and stresses are important aspects of assessing war’s costs. The diagnosis and socialized reality of PTSD provide key tools for responding to veterans’ psychological and moral injuries, but their limitations grow worrisomely apparent as well. As one soldier told us, “The problem with PTSD is that it lets everyone put

⁴² Bickford, Andrew. (2010, September 30). “Shadow Elite: Pat Tillman & Why Soldier Hero Worship Serves the Powerful...Not the Soldiers.” *Huffington Post*. Retrieved from <http://www.huffingtonpost.com/andrew-bickford/emshadow-eliteem-pat-till b 744890.html>.

⁴³ Meincke, Paul. (2012). “Veterans Return Medals During NATO Protest.” *ABC Eyewitness News*. Retrieved from <http://abclocal.go.com/wls/story?id=8669859>

⁴⁴ Aziz, Nahid. (2014). “Psychological Impact of War on Afghans.” Unpublished manuscript, American School of Professional Psychology, Argosy University, Washington, DC.

everything about the wars onto the individual soldier.” From a society-wide standpoint, PTSD lets the rest of the nation off the hook.

When an individualizing and decontextualized condition is treated as a stand in for the effects of the wars as a whole, we elide critical questions. Discourses around PTSD cannot replace Americans’ asking what we have learned over the long years of multiple deployments, and how or whether these campaigns have purchased the world greater security. When we compartmentalize combat as only affecting the health of US veterans, or lives “over there,” in Afghanistan, Iraq and beyond, about which most of us know little, we shelter civilians. Genuine cost-accounting for war and participating in competent civilian oversight of the military is the work of a democratic citizenry as a whole. Such oversight has long been held necessary for preventing the emergence of *militarism*, memorably defined by Alfred Vagts as the condition of a society that “ranks military institutions and ways above the prevailing attitudes of civilian life and carries the military mentality into the civilian sphere.”⁴⁵

⁴⁵ Vagts, Alfred. (1937). *A History of Militarism: Civilian and Military*. New York: W.W. Norton & Company. (p. 12).