

Post-Traumatic Stress Disorder Among Veterans

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The psychological problems that develop as a result of involvement in war have had profound effects on the lives of veterans throughout the world. The guilt that many veterans associate with their time spent in combat can lead to the development of issues ranging from alcoholism to suicide to the development of post-traumatic stress disorder (PTSD). Although PTSD has only recently been recognized by the medical community as an illness, soldiers have been experiencing PTSD-like symptoms for some time. In the United States veterans of the Civil War suffered from what was known as “soldiers heart”; it was called “shell shock” after World War I and “combat fatigue” after World War II. All of these terms refer to the emotional distress that soldiers experience after committing or witnessing the atrocities that occur during a time of war. Although the majority of returning soldiers do not suffer from PTSD, it remains imperative for those who do to seek treatment as soon as possible. Many researchers have recently brought public attention to PTSD and the need to reduce the stigma associated with seeking help for mental disorders within the military (Rowan 2006). The military itself has also begun to bring awareness to the importance of seeking psychological treatment, but much work remains in order to ensure that all soldiers who suffer from the disorder receive proper care.

Scholars have examined many aspects of PTSD, including the percentage of returning soldiers who suffer from the disorder, how many soldiers access services that treat it, the barriers that are often encountered when seeking treatment, and the effects the disorder can have on family members. But it is not only scholars who have brought

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attention to PTSD. It is important to recognize other groups, such as veterans organizations, that have brought this issue to the forefront. The current war in Iraq and Afghanistan has produced another generation of veterans who suffer from PTSD, and the role of the government in the development of the disorder has led many to wonder whether the government should be taking a more responsible role when it comes to the mental health of its soldiers.

Recognition of PTSD

In 1980, the American Psychiatric Association (APA) recognized PTSD as an official psychiatric disorder in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM III)*. The *DSM* presents the diagnostic criteria for PTSD and states that it is “apparently more severe and longer lasting when the stressor is of human design” (*DSM III* 1987: 248). This implies that when the stressor or traumatic event occurs during war or in a criminal assault, as opposed to during a natural disaster, the individual’s PTSD is likely to take a more severe form. Establishing PTSD as a psychiatric disorder gives veterans the assurance that the symptoms they are experiencing represent a natural and acknowledged reaction to the atrocities of war.

PTSD involves reactions to specific traumatic events that anyone might find it difficult to deal with (Koopman 1997: 831). Although all wars are fought under different circumstances and in different environments, a common occurrence is the death of both soldiers and civilians. However well trained they are for combat, soldiers who witness violence can experience profound psychological problems. *DSM IV* classifies varieties of PTSD according to onset and duration. It distinguishes among acute PTSD (in which duration of symptoms is less than three months), chronic PTSD (in which symptoms last three months or longer), and delayed onset PTSD (in which at least six months pass between the traumatic event and the onset of the symptoms) (2000: 465). Further study of PTSD has discovered these different forms of the illness that individuals may experience.

PTSD Among Veterans

Although PTSD symptoms have been present in soldiers

throughout many wars, it was after the Vietnam War that real action eventually brought the illness to public attention. The National Vietnam Veterans' Readjustment Study (NVVRS) was conducted in 1983 in response to a congressional mandate for an investigation into PTSD and other post-war psychological problems. Presenting its conclusions to Congress in 1988, the NVVRS found that 30.9% of Vietnam veterans had developed PTSD at some point in their lives and an alarming 15.2% still suffered from the disorder (Schlenger et al. 2007: 470). However, there was much criticism of the study because it was entirely based on self-reports of symptoms and stressors; some were skeptical of the figures (Dohrenwend et al. 2007). To see if they could create a more accurate picture of PTSD among Vietnam veterans, Bruce Dohrenwend and his colleagues decided to create a study using the findings from the NVVRS study along with military documents, and historical accounts. Dohrenwend et al. found that the current prevalence estimate was 9.1% and the lifetime prevalence estimate was 18.7% (2007: 462; also see McNally 2007: 481). Despite discrepancies between the two studies, it is clear that a significant number of Vietnam veterans are suffering from PTSD and that the need for treatment and care is essential within the Federal Department of Veterans Affairs.

Many veterans of the first Gulf War (1990-1991) have suffered from PTSD as well and some continue to deal with the effects of their combat experience. A study that focused on PTSD symptoms among veterans from the Gulf War found that there were two trajectories across time. The first trajectory, representing 57% of the sample, involved low PTSD symptoms with little increase over time. The second, representing 43% of the sample, involved higher levels of initial PTSD symptoms with a significant increase over time (Orcutt 2004: 1999). The first of three times at which data was collected in the longitudinal study occurred within five days after soldiers returned from the Gulf War. After data from the other two points in time (two years later and then four years later, respectively) were collected and analyzed, researchers isolated the two trajectories. The first trajectory falls under the category of acute PTSD, while the second trajectory reflects the definition of chronic PTSD, as the symptoms lasted longer than three months.

This study also examined seven different variables as predictors of certain trajectories, finding that women, those of minority/ethnic status, the less educated, and those who reported more exposure to combat were more likely to be in the second trajectory as opposed to the first (Orcutt 2004: 200). These predictor variables are consistent with previous research. In 2003, for example, a study of 15,000 Gulf veterans and 15,000 non-Gulf veterans found that those screening positive for PTSD criteria were more likely to be female, older, non-white, in the enlisted ranks, and in the Army and National Guard (Kang 2003: 145). Another study looked specifically at female veterans use of VA health services in 1992 compared to male veterans (Hoff 1998). Hoff et al. found that females were less likely than males to utilize the VA health services and that lower use of outpatient services was specific to women with mental disorders (1998: 1117). The low service utilization of VA mental health services in women compared to men may indicate that it is necessary for the VA to create a more accessible environment for women who have developed mental disorders. As there are many variables that can determine who is at a higher risk of developing certain disorders and who is more likely to seek treatment for their illnesses, there remains a need for more research in order to better predict who may develop PTSD and who is more likely seek treatment.

A recent study that examined soldiers and marines who were deployed in Iraq and Afghanistan found that those deployed in Iraq had higher rates of PTSD on returning from duty than those who returned from Afghanistan, with percentages for the former between 15.6 to 17.1 and 9.3 percent for the latter (Hoge et al. 2004: 13). The researchers also found a strong relationship between the prevalence of PTSD and combat experience such as being shot at, having to handle dead bodies, witnessing the death of a friend, and killing the enemy (Hoge et al. 2004: 18). Soldiers and marines returning from Iraq reported higher levels of combat experiences than those returning from Afghanistan, with 71 to 86 percent having reported engaging in firefights in Iraq compared to 31 percent of those deployed in Afghanistan. This further supports the notion that the amount of combat exposure might predict who will develop PTSD. The re-deployment of troops in the current “War on Terror” might return

soldiers suffering from PTSD back to combat, which could be detrimental to their recovery. Further research is necessary in order to fully grasp the effects the current war is having on soldiers' mental health.

Service Utilization, Barriers to Care, and the Military

It has been reported that many veterans diagnosed with a mental illness such as PTSD have been reluctant to seek treatment. For example, the previous study on the prevalence of PTSD in soldiers returning from Iraq and Afghanistan found that of those who met the criteria for having a mental disorder, only 38 to 45 percent were interested in receiving help and only 23 to 40 percent had received professional help within the previous year (Hoge et al. 2004: 19). Other studies have also explored the reluctance of soldiers to seek care for their psychological disorders (Britt et al. 2007). A study conducted by Britt found that soldiers who were assessed for psychological problems reported more discomfort in talking about their psychological problems than medical problems, especially upon returning with their unit (2000: 1611). Those soldiers were also less likely to follow through on a psychological referral than a medical referral, which further indicates the reluctance of soldiers who suffer from mental illnesses to seek treatment (Britt 2000: 1611). A study that examined the prevalence of PTSD among veterans who made an outpatient visit at one of four VA hospitals during 1999 found that 11.5% of the patients suffered from the disorder (Magruder et al. 2005: 174). Of those who suffered from PTSD, 47.7% had used mental health specialty care, in addition to primary care, over the previous 12 months and the use of mental health specialty care allowed the provider to have a more accurate detection of PTSD, with 78% of patients being diagnosed with PTSD as opposed to 17.8% of those who were only seen in primary care (Magruder et al. 2005: 175). The need for patients to seek assistance is essential for being properly diagnosed and being able to transition back into civil society.

Although there has been research that shows trends of low service utilization by soldiers returning from war who suffer from mental disorders (Kessler 2000), a study conducted by Christopher Erbes et al. (2007) found a different pattern. Two hundred and twenty soldiers

who returned within a six-month time frame from Operation Enduring Freedom and Operation Iraqi Freedom participated in a mailed survey. Erbes et al. found that 56 percent of those who screened positive for PTSD (using a 17-item self report questionnaire) had mentioned receiving individual therapy, group therapy, and/or psychiatric medication since their deployment (2007: 362). Unlike previous research that has found relatively low use of mental health services, this study finds a higher use, which could indicate that returning soldiers are becoming more accepting of the problems they have developed due to their experience in war.

Britt et al. explain the apparent reluctance of soldiers to seek treatment as a result of the stigmatization associated with admitting a psychological problem (2007: 159). This stigma exists in society as well as in the military and can be a public or a self-stigma. Britt et al. present three responses that the public exhibits with regards to people who have mental health disorders: authoritarianism, in which individuals are seen as negligent and unable to take care of themselves; fear and exclusions, in which those persons with mental illnesses are feared by society; and benevolence, in which people tend to hold the view that people with psychological problems are childlike or naïve (2007: 158). The public's stigma towards people with mental illnesses can have severe consequences for soldiers who suffer from psychological disorders because they may fear how society will view them and therefore be reluctant to admit that they have a mental problem.

Lt. Col. Anderson B. Rowan and Lt Col Rick L. Compise admit that stigma is an important barrier to treatment, but they also emphasize that other barriers exist (2006: 1123). In their review of literature they mention the 1999 Mental Health Report of the Surgeon General which found that many individuals seeking treatment encounter barriers, including the stigma surrounding behavioral health treatment, apprehension of confidentiality, distrust of the system, fear of being sent to the hospital, and lack of resources, such as insurance (Rowan et al. 2006: 1123). Concerns of how seeking treatment would impact one's career is another barrier that is highlighted in the Department of Defense survey, in which 49% felt that seeking behavioral health care would probably damage their career in the military (Rowan et al. 2006:

1123). There are many factors that can contribute to an individual not seeking treatment for their problems, such as a fear of being demoted, and it remains essential to break down these barriers in order to give soldiers the care they deserve. An important way of doing this would be reducing the public's stigma as well as the military's reactions to psychological illnesses.

Jamie Davis et al. used focus groups consisting of Department of Defense primary care providers and military beneficiaries in order to understand problems with provider-patient communication (2007: 54). Four major themes emerged. The first dealt with provider-patient trust, which was difficult to establish because providers and patients are often deployed or reassigned, disrupting the bond between patient and provider (Davis et al 2007: 55). The second theme that emerged was validity of symptoms and concerns, in which both beneficiary focus groups and providers recognized that there might be people who do not legitimately have a mental health problem but are claiming they do for the benefits (Davis et al. 2007: 56). Many patients feel that their providers do not believe them. Health information exchange is the third theme and both patients and providers felt that the limited amount of time providers spend with the patients and the number of patients they see hinder the possibility for accurately detecting symptoms of PTSD (Davis et al. 2007: 56). The fourth and final theme that appeared in this study was health care system barriers. Both patients and providers expressed frustration with the military health care system, especially the difficulty in scheduling an appointment, its short duration (15 minutes), and the inability to meet with the same provider (Davis et al. 2007: 57). These four themes highlight the relationship (as well as lack of relationships) that providers and patients within the military experience and the need to improve the communication between them.

The American Psychological Association (APA) recently released a report that discussed the need to improve the military health care system. This report documented a 40% vacancy rate in active duty psychologist positions in the Army and the Navy (Borenstein 2007). The report also found that the percentage of military mental health experts that were trained to deal with PTSD was only 10 to 20 percent (Borenstein 2007). The need to further strengthen the military health

care system is essential for the well being of veterans and this report is evidence that the change must occur soon. It is apparent that the military is making attempts at improving PTSD knowledge among the commanders and soldiers, as they announced on July 18, 2007 that they were enforcing a new mandatory PTSD and Mild Traumatic Brain Injury (MTBI) Chain Teaching Program to be completed by all soldiers by October 18, 2007. The objective is to provide leaders, soldiers, and their families with a general knowledge of MTBI and PTSD and to be able to identify symptoms in order for them seek treatment. Along with a standardized script the commanders will use audio-visual aids, which will give the soldiers and their family members a better understanding of the symptoms (Harben 2007). Monitoring the application of this program and how effective it is will be essential for future research.

PTSD and Family

Research on PTSD has begun to examine how the disorder affects an individual's family life. For example, a recent study focuses on the relationship between domestic violence and PTSD among active duty military and veterans (Gerlock 2004). This study found that there is a strong relationship between domestic violence and PTSD severity. There were four phases that the participants had to complete: assessment, orientation, rehabilitation, and maintenance (Gerlock 2004: 470). Thirty-seven percent made the transition from rehabilitation to maintenance, while 67% did not complete the program (Gerlock 2004: 472). Those individuals who completed the program, who attended an average of 36 weekly sessions and who took 7 to 15 months to make the transition into the maintenance phase, were more likely to have lower levels of PTSD. Those who dropped out of the program were more likely to have higher levels of PTSD (Gerlock 2004: 472). It is important for soldiers who do suffer from PTSD to seek treatment and continue the programs for their own benefit as well as for those around them.

Another area of exploration has been on the impact of war service on veterans' perception of family life. When examining Vietnam veterans, C. Hendrix and L. Anelli found a significant association between combat experience and psychological impact, which is to say

PTSD symptoms, and between psychological impact and family satisfaction and functioning (1993: 90). This indicates that wartime service may have an indirect impact on family satisfaction and functioning.

Assessment of the Literature

All told, these studies bring attention to the many issues that veterans who suffer from PTSD may experience. The need for better integration in transitioning soldiers from a wartime society to a civilian society is essential, as is the need to bring more attention to the care veterans receive in order to secure their health and the health of those who surround them. There are many areas of exploration dealing with veterans who experience PTSD: the establishment of PTSD as a disorder; analysis of the percentage of veterans who suffer from it; consideration of the numbers who receive mental health services and the barriers that exist in utilizing them; debates about the responsibility of the military; and study of social interactions and perceptions of those suffering from PTSD. These issues have been brought to the public's attention over the past several decades and have resulted in further research into PTSD. Although there have been many individuals who have contributed to establishing the importance of PTSD among veterans, the role that veterans groups and organizations have played has been especially important.

The Role of Organizations

Veterans have been forced to confront a wide array of issues, struggling to uphold their right to access medical care, to establish recognition by the medical community, and to bring attention to the stigma of mental health disorders within the military. All of these obstacles, as well as countless others, have largely been addressed through increasingly numerous and active grassroots or veterans organizations. Soldiers who return from war may experience a physical disability or a psychological disorder and it is imperative that they receive proper care and compensation for their illnesses. On the individual level, many veterans may not be able to have their voices heard or their needs provided for; therefore, many work collectively and these organizations promote an agenda to uphold the rights of

veterans and expose the lack of care soldiers receive.

Indeed, it was through the efforts of veterans groups and other individuals that PTSD was recognized as a disorder. Although veterans have experienced symptoms of PTSD throughout the course of many wars, it was only acknowledged by the American Psychiatric Association (APA) as a diagnosis in 1980. After the U.S. offensive into Cambodia, anti-war psychiatrists such as Robert Lifton and Chaim Shatan formed a loose association with Vietnam Veterans Against the War (VVAW) to spread awareness of the psychological trauma that many veterans experience (Scott 1990: 300). In 1970, the president of VVAW invited Lifton and Shatan to sit in on the New York City chapter's informal session in which veterans discussed their war experiences. After sitting in on the sessions, the two psychiatrists realized that the "VVAW had developed on the streets a political strategy and a treatment" for what was then known as "delayed gross stress reaction" (Scott 1990: 300) and from that point on they worked diligently in getting Post-Vietnam Syndrome (later called PTSD) recognized by the medical community. After the publication of articles in the *New York Times*, the release of books, Senate testimony by Lifton, and the creation of the National Veterans Resource Project (NVRP), the APA formally recognized PTSD in *DSM-III*. This has greatly altered the way in which veterans are treated and compensated. Through the efforts of many individuals and organizations, PTSD among returning soldiers is now seen as a normal response to the involvement in war.

The current "War on Terror" has re-ignited concern about PTSD among returning soldiers. Many soldiers are exposed to violent and traumatic events that may lead them to develop PTSD. This war has brought attention to the number of soldiers returning from Iraq who may suffer from PTSD as well as to the quality of treatment they are receiving. Veterans groups as well as organizations have contributed greatly in bringing PTSD among soldiers to public attention and they have exposed the ways in which soldiers are treated within the military for the disorder.

Recent revelations of the poor mental health treatment that soldiers have been receiving at Fort Carson in Colorado constitute only one of many scandals that have arisen in recent years. One group that has

been an advocate in exposing the way in which veterans are treated is Veterans for America. Steve Robinson, director of veterans' affairs for the organization, and Andrew Pogany, a former soldier and investigator for Veterans for America, have been especially effective. The poor treatment was uncovered after many soldiers reported that they were being deployed to Iraq with brain injuries or were being punished for behavior related to combat exposure, which was further highlighted when statistics showed that of 276 soldiers discharged for personality disorder, 56 in fact had PTSD (Kennedy 2007). Veterans for America asked for an investigation into the treatment of soldiers by the Army Surgeon General, but no one from the Inspector General's office spoke to them before submitting the report, which ultimately said that there were no problems. This prompted Robinson to go to Congress, after which senators asked the Government Accountability Office (GAO) to investigate the mental health cases (Kennedy 2007). The letter to the Comptroller General of the GAO was signed by U.S. Senators Barack Obama (D-IL), Barbara Boxer (D-CA), Kit Bond (R-MO), Daniel K. Akaka (D-HI), Tom Harkin (D-IA), Joe Lieberman (I-CT), Patty Murray (D-WA), Claire McCaskill (D-MO), and Bernie Sanders (I-VT). The letter addresses the issue of the stigmatization of PTSD within the military and asks for a system-wide investigation of the mental health care capabilities of the Department of Defense (DoD), concluding that:

We seek to ensure that the DOD has the resources necessary to diagnose and treat service-connected injuries that impact the mental health of U.S. service personnel. It is vital that the U.S. military ensures it is treating the mental health needs of our forces with the same priority and resource investments it is devoting to physical injuries. (Obama et al. 2007)

There are numerous individual accounts of the poor treatment soldiers experienced from the military at Fort Carson. One of these was the story of Pvt. Tyler Jennings who, after being denied treatment, had taken steps toward suicide one night by tying a noose around his neck and drinking alcohol (Zwerdling 2006). Not only was Jennings denied treatment but he was also charged with offenses including drug

use, failure to report, and making false statements (Emery 2006). He was denied treatment after the sergeants discovered symptoms that he had developed upon return from Iraq. These symptoms, recorded by a staff member, included feeling helpless, worthless, and often crying (Zwerdling 2006). Jennings believes that the Army is not recognizing his PTSD because upon leaving the Army he would be entitled to certain benefits that he feels they do not want to give him (Emery 2006). Although there have been more extreme cases that have resulted in suicide, this example shows the way in which many soldiers have been treated at Fort Carson. Even though many members of the military staff at Fort Carson denied these allegations, the stories of soldiers' personal experiences have brought more exposure to the stigma associated with PTSD and the consequences that have resulted from it.

After the treatment of soldiers at Fort Carson was revealed, a training program was enacted to help educate leaders within the military on PTSD. When NPR's Daniel Zwerdling visited Fort Carson and talked to some of the commanders, however, he concluded that the military's demand for discipline conflicted with the goals of this training. The major goal of this new training program is to educate commanders in order to give them a better understanding of the symptoms of PTSD. Yet Command Sergeant Major Terrance McWilliams suggests that he will continue to punish soldiers who show signs of PTSD, such as excessive drinking or drug use, because the Army has a responsibility to preserve order and discipline (Zwerdling 2007). Certain senators became increasingly more concerned with the care of soldiers at Fort Carson—in particular Obama, Boxer, and Bond—and sent their staff to report on the conditions. This visit resulted in a letter written on May 22, 2007 to the Secretary of Defense Robert Gates. In the letter, the Senators indicated awareness of the allegations that have surfaced at Fort Carson and noted that

While Ft. Carson has taken some important steps to improve care for soldiers including implementing mandatory TBI [Traumatic Brain Injury] screening and enhancing the pre- and post-deployment screening process, the reality remains that the base is facing significant challenges in providing mental

health care services. The Department of Defense Mental Health Task Force recently found that the stigma of mental illness and injury is pervasive across our Armed Forces and Ft. Carson is proving to be no exception. (Boxer 2007)

The concern to improve the mental well-being of soldiers has been tackled by certain Senators, but organizations such as Veterans for America also continue to bring awareness to issues at Fort Carson. In early 2007, Robinson and Pogany led a group of congressional staffers for a two-day visit to Fort Carson (Burnett 2007). Veterans for America encountered personal accounts of the mistreatment in the mental health care of some soldiers at Fort Carson, which led to a further investigation on their part. After learning that other soldiers experienced the same treatment, Veterans for America brought public attention to the issue, which caused members of Congress to become involved. Veterans for America continues to monitor the mental health treatment of soldiers at Fort Carson. Without its involvement and advocacy, the inadequacies of mental health received by soldiers may have gone unnoticed by Congress for a longer period of time.

Responsibility of the Government

The importance of treating PTSD early in its development is crucial for the well being of soldiers and the Government has a responsibility for making sure that all soldiers are being properly diagnosed and treated. In the coming years, there will be thousands of soldiers returning from war in Iraq and Afghanistan and it is necessary that these men and women are properly screened and diagnosed in order for those who do show signs of PTSD to have treatment available to them. The soldiers who are involved in war have the right to access mental health care services and should not feel ashamed or looked down upon by their peers and commanders when seeking those services. The military has an undeniable role in making sure that all soldiers have access to treatment, whether physical or mental, because the military institution is responsible for the health of those who serve in their organization. As returning soldiers from Iraq and Afghanistan become more numerous, the need for proper mental health treatment is increasingly vital. There are many people who believe that the

government is not providing sufficient mental health services because they are perceived as too expensive. Ford, Huber, and Meagher (2006) contend that the increasing cost of the war in Iraq, now estimated in the trillions, is a major factor in the government's refusal to accept full responsibility for helping soldiers find mental health treatment. They believe that "those in positions of power whose ideology embraces limited utilization of healthcare benefits, the deregulation of healthcare providers, and the reduction of federal spending for healthcare contribute to the deterioration of the provision of healthcare to our returning veterans" (Ford et al. 2006). This argument, in part, plays into the controversies of the current administration's "War on Terror" because the lack of responsibility towards mental health care is related to the political propaganda of the Bush administration. Ford et al. worry that

The redefinition of increasingly prevalent, chronic, costly disorders like PTSD and substance abuse as "spiritual" disorders or "moral" issues could open the door to outsource them to unregulated faith based care providers rather than to medical treatment. Licensure strictures, oversight requirements and malpractice suits are avoided. It shifts the burden of responsibility from government to the patient, effectively rationing the medical care of the veteran who suffers from service connected disorders and putting them at risk for additional harm from unregulated providers [..] The cost is dramatically lowered. This 'shifting' may well violate medical ethics by making budgetary concerns the primary issue rather than the moral and ethical obligation of putting veterans first. (Ford et al. 2006)

The current slogan of "support our troops" seems to be at odds with the actions of federal officials who have sought to reduce funding of the Veterans Administration. President Bush himself has proposed cutting the VA budget by \$350 million ("Democrats" 2005).

Peter Kilner (2004) argues that the Army medical community is making attempts to address PTSD through the establishment of pre- and post-deployment questionnaires in which seven of the seventeen

questions focus on depression, anxiety, or PTSD. The problem, he argues, is that the military medical community is not addressing the issue of what a soldier does, but rather focuses on what happens to a soldier. He believes that military ethicists need to take a leading role in bringing awareness and discussion on the morality of killing in order to prevent and better treat psychological trauma that comes from the guilt many soldiers have in killing during combat (Kilner 2004). The act of killing in combat has been found to lead to guilt, which in turn may lead to the development of PTSD. Kilner (2004) argues that the military is taking a role in addressing PTSD in returning soldiers but has failed to open a dialogue with them about the justification and morality of killing while in combat. The guilt associated with killing in combat is a normal and healthy reaction, but is one that needs to be publicly talked about in order for soldiers to make sense of their actions (Kilner 2004). When treating those who suffer from PTSD, it is essential to provide soldiers with the ability to comprehend that the guilt associated with the atrocities they may have committed during war are normal reactions.

According to David Grossman (2005), it is imperative to begin the discussion about the morality of killing before deployment. He believes that soldiers need to be prepared emotionally before entering in combat situations because if they know ahead of time that killing someone may be morally justified then they may be less likely to develop PTSD. He also believes that the military is taking incremental steps in the right direction, but contends that the soldiers need to be more mentally prepared (Grossman 2005). Grossman argues that the military must take a more responsible role in preparing them psychologically before deployment because if training and preparation are not undertaken, the development of PTSD becomes more likely.

In *Achilles in Vietnam*, Jonathan Shay (2004), a psychiatrist who focuses on PTSD, argues that combat trauma is a result of bad leadership. He notes that it is important to improve both training and leadership if the military truly wants to prevent psychological injuries on the soldiers. Shay also brings awareness to the importance of civilian support for the soldiers, despite ethical and political disagreements. With regards to ways in which improvements in the military can reduce permanent psychological injury, Shay suggests that

“preservation of the social and moral cohesion of the soldier’s face-to-face combat unit ranks highest among things that must be done” and that “the official and folk culture of the American military must change so that grieving enjoys high status—is valued, not stigmatized” (189). Although men and women go through debriefing when they return from war, it is important that they do this in units rather than as isolated individuals and equally as important is the removal of the stigma associated with having a mental health disorder.

Another perspective comes from Sally Satel (2006), who suggests that the Department of Veterans Affairs should be spending more time and money focusing on soldiers with psychological disorders returning from more recent wars as opposed to the Vietnam-era veterans who are experiencing delayed PTSD. Satel suggests that the VA differentiate among several groups of delayed-benefit applicants: the chronically afflicted veterans who probably never received sufficient treatment and are good candidates for long-term care; the veterans who experience reactivated symptoms from war trauma and who will likely respond to therapy and therefore do not require long-term support; and those who received diagnoses of PTSD years after their involvement in war and who deserve treatment to the extent that it will help, which rarely means long-term disability payments (Satel 2006). Satel offers these suggestions after a report was released suggesting that the Department of Veterans Affairs is paying an annual cost of \$4.3 billion in compensation to veterans suffering from PTSD. This compensation is being dispersed among twice as many veterans as it was six years ago. Satel believes it is very likely that some of the veteran baby-boomers who have in recent times filed claims have done so out of the need for financial security and not for medical need (2006). Although it is possible that some veterans from the Vietnam War may be looking for a financial safety net, it is imperative to maintain focus on treating all soldiers who do suffer from PTSD.

The government should be taking a more responsible role with regards to the mental health of returning soldiers because the government makes the decision to go to war and it is the soldiers who put their lives on the line, risking themselves both physically and psychologically. The military recruits men and women, trains them to fight, and then deploys them in a certain country, so they therefore

should have an active role in issues that arise in the aftermath of their experience in combat. The military has made progress in dealing with the mental health of returning soldiers by implementing pre- and post-deployment questionnaires as well as creating the PTSD/MTBI chain teaching program that trains leaders and educates soldiers on the symptoms and signs of PTSD and MTBI. This is a start on the part of the military in having a more active role in the mental health of returning soldiers. But many soldiers still feel that they will come across as weak or be penalized for seeking mental health treatment and it is the role of the military to make sure that the stigmatization of seeking mental health services is eradicated. It is imperative that soldiers are provided with information before deployment that will help prepare them for their experiences in combat. It is also important to have discourse upon returning from war because it allows soldiers to discuss their experiences and talk to others who may have endured the same traumas. Although this will be a challenge for the military, it is vital that the soldiers come to terms with the seriousness of the psychological and physical costs of warfare.

Many soldiers have encountered difficulties upon returning from war due to the traumatic experiences they have endured, but these psychological effects have only recently been recognized by the APA. Since 1980, researchers have examined many issues regarding PTSD among veterans. These issues have ranged from how many soldiers develop PTSD, to the factors that may predict who will be affected by the disorder, to the percentage of veterans who utilize mental health services, and to how PTSD may affect family members. The work of veterans groups and other organizations have contributed greatly to the general knowledge on the psychological toll of war. They have made progress and continue to do so with regards to the mental health of veterans and their importance is evident through their efforts in the recognition of PTSD by the APA, the growing awareness of Gulf War veterans' health issues, and the investigation into the poor treatment of soldiers at Fort Carson. This work has led many to question the role of the government and whether it should be taking more responsibility for the mental health of their soldiers. Although there are various views on this issue, it is evident that the government does have a responsibility to care for soldiers and must provide them with

better mechanisms that would prevent the development of PTSD. Not only should there be programs put in place that would mentally prepare soldiers better for their deployment but there should be proper mental health care facilities and staff that are capable of treating PTSD when they return. If the government were to take a more responsible role in caring for the mental health of soldiers, then there may be a reduction in the number of soldiers who develop PTSD.

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