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VETERANS ON TRIAL

THE COMING COURT BATTLES OVER PTSD

BARRY R. SCHALLER

Foreword by Todd Brewster

Potomac Books
Washington, D.C.

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Breeding Ground for PTSD

Iraq and Afghanistan

The mental stress of soldiers and veterans deployed to Iraq and Afghanistan is receiving an unprecedented amount of media attention. Reports come, not only from professional journalists and citizen journalists, but from firsthand accounts of participants on the ground published in video postings, in blogs, and on social networks. Numerous research studies and surveys evaluate this aspect of today's ongoing wars. The personal stories of veterans are my starting point.

VIEW FROM THE GROUND: PERSONAL STORIES

Art described his first day as a Marine in Kuwait:

> On my first day, we drove in pulling guns with our trucks. After the first mile, we got our first firing mission. We had six guns in our unit and probably shot five rounds each. We didn't know what we were firing at. . . . About six miles in, we saw what we had hit. Mostly it was buildings, but there were some bodies. . . . It hit me when we had to pick them up. They were Iraqi soldiers. It wasn't bad when we were just driving by. You could see and smell it but kind of get over it. It was when we stopped and they told us we had to collect everything. We had to line up and cover the bodies. . . . It was different then because you touched them. That's the first time I had ever seen a dead body except in a funeral. The first thing you think of is 'better them than me.' Then you realize that their mothers wanted them to come home just like my mother wants me to come home.

Art said that after the first combat experience, the soldiers began to question their mission.

> I think what got to me was when I started to question why . . . because everybody was saying it's just for the oil. . . . The nights got real long after that. We were so close to the shore that you could hear the radio calling for naval gunfire. . . . You could hear the ships fire a round and hear them land. . . . The next day you could see the holes in the ground, and you got these Iraqis walking up to us for food, and we have to feed them . . . and you can't sleep at night because you have to watch them. That's when it really got to me. The first time, I thought I was ready for it, but I wasn't. . . . How can you be ready for it? . . . If you haven't been there, you can say you understand, but you can't.
>
> I'm 100 percent sure I'm not alone in this. . . . One guy . . . they sent back to the ship. He just froze and was no good to anybody. That was one of the main reasons why I didn't want to say anything. When they sent him back, everybody started talking about him. I didn't want that to be me. There was nothing in our training about killing and the psychology of it. They didn't train you about the effects of what happens when you [kill someone]. They just train you to shoot a weapon. . . . In the artillery, you shoot over your own guys. They probably figure you won't see and it won't hurt you. We didn't know we'd have to clean it up. We had to cover up the bodies and line them all up. . . . I just looked at it and wondered why . . . ? What for?

Alan's combat experience was in Iraq. He envisioned a career in the military, but his alcohol problem ruined that. He was in a rehabilitation program while he was in the Marines. The rehab staff tried to help, but he was eventually discharged four months early. During his seven months in Iraq, conditions were bad. Insurgents were everywhere, schools were blown up, and the people were afraid of Americans. The troops were mortared almost every night; ambushes were common. Alan's platoon worked to win over the civilians while avoiding getting shot.

Alan recalled, "I was on point every time we went out on patrol. I volunteered. . . . I didn't want to be anywhere else on the patrol. I had to make sure we

weren't walking into an IED [improvised explosive device]. We worked with bomb units. Every time we'd see an IED we'd cordon off the area and wait for them to show up. . . . The main thing they tried to teach us was that complacency kills." The tension and anxiety took a toll on Alan.

Ray was deployed twice to Afghanistan. The first time was on September 11, 2001. "We heard about 9-11 on the radio, and it was a shock to us. Once the war started, my life got easier . . . because it was just nonstop training. . . . It's hard to explain how those four years felt like a lifetime."

His role as a sniper was not what he expected. "You're not kicking doors down, and you're not face to face with people. . . . You still go . . . on missions. The sniper may sit for two or three days and watch. . . . It was an amazing job. I loved it. It's just overly romanticized in the movies."

Ray still feels deeply guilty about several deaths that he thinks he could have prevented had he not opted out of a mission. He learned later that his sniper skills had been desperately needed to save the lives of several soldiers. He believes that "because I was a glory hound, I passed up where I was supposed to go and maybe my parents would be mourning . . . instead of their parents." He learned later that the soldiers trapped by enemy fire had been calling for him.

Linda felt in constant danger during her deployment to Iraq

> because we were supplying the infantry. I had an ammunition truck. My friend, the only girl out there with me, had her fuel truck. We had the most dangerous ones. If you got hit, you were done. We didn't have a lot of encounters, and I was never able to shoot back because we couldn't see the people shooting at us. . . . If you can't see, you can't shoot. In a way, I'm glad because I didn't want to shoot anyone. I think that would mess me up even more. . . . I almost had to when we had mortar rounds shot at us and I was on top of the truck.

Linda recalls,

> My girlfriend was in an accident when her truck driver flipped over the truck. She was pretty badly injured. We drove her back to the base. Her leg was broken. Later, she had the choice to go back home or to come

back. She came back to us. . . . I said like 'Oh my God, I was lost without you.' I was the only girl while she was gone. . . . It was kind of depressing for me. . . .

I have a lot of intense dreams and nightmares. I have dreams all the time of my gun not working. My counselor says that is very common. I've had dreams that I've gotten shot in the leg. I can actually feel them in my dreams, which is weird. I'll wake up and my leg feels weird. . . . Right after I got back, I heard a plane going over and I had to look up because it sounded exactly like a mortar round. I knew I was in a safe place, but my reaction was to look and make sure. I knew there was something wrong, but I didn't say anything until I got out of the service and got to the VA. I was scared at times, but I don't think I had PTSD there. When I got back, it was a whole different story.

During Dax's eight-month tour in and around Afghanistan on ship, he was not "in direct center line of fire," but he was "there for [his troops]." "In my first Iraq tour, my company and 'Force Recon' pushed through the berm between Kuwait and Iraq and fought all the way to Tikrit." After that tour, he reenlisted before his four year commitment was up. He was slated to be an instructor for the school of infantry, but that plan changed. "My Marines came and asked me to do a third tour of combat because they said they felt safer with me beside them . . . so I went with them. . . . I was planning on making it a . . . lifelong career, but due to the injuries I received on my third tour, I was medically retired."

In Iraq, "we saw a lot of explosions . . . a lot of getting blown up. . . . My wingman [and I] were the . . . best gunners in the company. . . . Death was a constant presence. At one point, our vehicles ran into a 'killbox' [heavily protected enemy territory] and were pummeled by gunfire and rocket propelled grenades." Although Dax and his wingman survived the attack, Dax realized,

> Most people get a sense of being afraid of dying, and adrenaline kicks in. . . . I didn't have that fear because I had realized at that point . . . I was dead; I just wasn't dead yet. . . . I knew . . . there was no way humanly possible I should have made it through that, and because of that I literally had a gray spot of hair . . . in the middle of my head, come up within twenty-four hours. . . . I realized . . . that I was not gonna survive that, and I'd come to terms with that. My only plan was to take as many of them with me as I could. I was OK with it.

Dax sustained a serious shoulder injury repairing a 450-pound 25-millimeter gun during the attack and later had shoulder surgery.

After Dax was treated for damage to his feet from cellulitis, his vehicle commander asked him to return to the gunner seat, even though he had not even begun recovering. During his third tour, on July 25, 2004, Dax sustained serious injuries when he "quite literally got blown up. I had three land mines . . . that were stacked . . . on top of each other [go off underneath my vehicle]. . . . Shrapnel hit my helmet and took a piece out of it. . . . It broke my spine in two places and caused me to receive chronic disc [degeneration], meaning my discs are pretty much eating themselves up because they can't support anything after that amount of explosion." Beyond the chronic degenerative injury to his spine, Dax received other injuries, including TBI and hearing loss.

The combat experiences of these veterans varied greatly as to intensity and trauma. The causes of their PTSD doubtless can be traced to different sources. Some coped effectively during combat exposure whereas others struggled to adapt. The background that the stories provide is essential as a foundation for the next sections, an overview of significant insights into the mental health consequences of these wars.

RAND CORPORATION STUDY

In 2008 the Rand Corporation, a nonprofit research organization, published a comprehensive report on the scope of mental health and cognitive conditions that troops face when returning from deployment to Iraq and Afghanistan, the costs of these conditions, and the adequacy of the care system.[1] At the time the study was completed, 1.64 million military service members had been deployed in support of the wars. More recent estimates, in 2011 after ten years of war, place the total numbers at more than 2 million troops deployed in both theaters since September 11, 2001.[2]

The Rand study was guided by three overarching questions: (1) What is the scope of mental health and cognitive problems faced by returning troops? (2) What are the economic costs of these mental health and cognitive conditions to

the individual and society? (3) What are the existing programs and services available to meet the health-related needs of service members with PTSD or major depression? A related question pertained to the gaps in veteran services and what steps could close them. The Rand study, in brief, found that rates of PTSD, major depression, and TBI among veterans were relatively high when compared with the U.S. civilian population. The survey sample reported substantial rates of mental health problems within the preceding thirty days. Specifically, 14 percent were positive for PTSD and another 14 percent for major depression.

Based on deployment figures as of October 2007, Rand estimated that 300,000 individuals were suffering from PTSD or major depression at the time of the survey. About half of those who met the criteria for PTSD and major depression had sought medical or psychiatric help for a mental health problem during the past year, about the same proportion as in the civilian population. The Rand report conceded that reserve units and those who had left military service were underrepresented in the study and that both groups may be at higher risk for these conditions. Rand also found that "too few" of those who sought help received high-quality care and that many barriers to getting treatment existed, including concern for lack of confidentiality and fear of harming military-career advancement or civilian job potential.[3]

CHARLES HOGE, MD, 2004 STUDY

An influential article in 2004 by Col. Charles W. Hoge, MD, and published in the *New England Journal of Medicine*, reported that the prevalence of PTSD in Iraq War veterans could be as high as one in five, depending on the frequency of firefight participation.[4] Using a broad definition of PTSD, this study found that 18 percent of an army study group that had been deployed to Iraq and 19.9 percent of a marine study group also deployed to Iraq tested positive for PTSD. When a strict definition was used, the percentages dropped to 12.9 and 12.2 percent, respectively.[5] Responding to the Hoge article, Dr. Matthew J. Friedman observed,

> There is reason for concern that the reported prevalence of PTSD of 15.6 to 17.1% among those returning from Operation Iraqi Freedom or Operation Enduring Freedom will increase in coming years, for two reasons. First, on the basis of the findings of the Fort Devens study [a study on the Gulf War reported in 1999], the prevalence of PTSD may increase considerably during the two years after veterans return from combat duty. Second, on the basis of studies of military personnel who served in Somalia, it is possible that psychiatric disorders will increase now that the conduct of war has shifted from a campaign for liberation to an ongoing armed conflict with dissident combatants. In short, the [existing] estimates of PTSD . . . may be conservative.[6]

HOGE AND SEAL STUDIES, 2009

Other recent estimates have produced predictions of PTSD as high as 20 percent in soldiers and 42 percent in reservists returning from the wars.[7] A 2009 study by Colonel Hoge and others, published in the *Journal of the American Medical Association*, reported, "19.1% of soldiers and Marines who returned from OIF [the Iraq War] met the risk criteria for a mental health concern, compared with 11.3 % for OEF [the Afghanistan War]." Further, "31% [of Iraq veterans] were documented to have had . . . at least 1 outpatient mental health care visit within the first year postdeployment."[8]

A study by Karen H. Seal and others found that 36.9 percent of separated Iraq and Afghanistan veterans enrolled in the VA health-care program had been diagnosed with mental health disorders, and more than 40 percent either had mental health disorders or were found to have psychological or behavioral problems or both.[9] Many other studies and reports, including reports by multiple mental health advisory teams (MHATs I- VI), corroborate the findings as to the anticipated prevalence of mental health problems among veterans returning from the current wars.[10] That the MHAT studies were conducted shows an encouraging level of attention to mental health issues.

STANFORD STUDY, 2009: A DYNAMIC MODEL

According to the 2009 Stanford study, the rate of PTSD among soldiers and marines deployed to Iraq may be as high as 35 percent, if one takes into account combat deployments plus time lags. The report states that the estimated rate is about double the rate from the raw survey data. The doubling is attributable to delayed onset, the time lag between the PTSD-generating event and the onset of symptoms, and to the fact that many of the service members surveyed will face additional deployments.[11] Although the prediction may be inexact

because of underlying assumptions and other factors, the study provides valuable insights into the future mental health condition of the soldiers. The Stanford researchers also concluded that multiple deployments raise each individual's risk of PTSD, while lowering the total number of cases. The greater number of individuals exposed to combat, however, the greater the total number of those with PTSD. In other words, the configuration of PTSD within the group would be different. The data also suggested that reservists show symptoms sooner than active-duty soldiers, and civilians tend to report symptoms sooner than military personnel.[12]

PTSD begins to affect a veteran's life as soon as symptoms occur, regardless of whether the veteran ever reports the symptoms or received a PTSD diagnosis. Mental health resources will be needed at the VA and elsewhere in society when the veteran seeks help or is ordered to get help. Clearly, this disorder will affect, not just mental health resources, but also society and its institutions, including the courts.

As noted, partial PTSD, in which one or more symptom criteria is absent, still constitutes a threat to veterans who are attempting to adjust to and cope with civilian life and to those in close contact with those veterans. In addition, PTSD symptoms that are not recognized or diagnosed can still present huge obstacles to success in life. There may be a significant gap between the number of veterans predicted to have PTSD and the number who are evaluated at all, much less treated. It is commonly estimated, for example, that the majority of people in the general U.S. population who suffer from mental health problems do not receive treatment for many reasons, including the serious stigma attached to such problems as well as access to health-care treatment. Even if veterans do seek and receive treatment, PTSD symptoms may come and go over long periods of time, and full remission may not occur.[13] These considerations are important for treatment purposes, and they are also important for purposes of understanding the potentially huge impact on America's legal, social, and economic resources. It is essential that PTSD be viewed as a public health problem, not just an individual mental health problem. Mental health workers who deal with veterans suffering from PTSD know that veterans rarely present themselves with direct reports of symptoms. They show up for a wide variety of reasons that include other injuries or illnesses, alcohol or drug problems, domestic problems, and family violence, along with a plethora

of other problems, including criminal arrests for operating under the influence, assault, theft, homelessness, minor assaults, or encounters with the police. Some patients show up for treatment at a critical juncture of their lives, such as at retirement. Veterans of all wars commonly show up at VA hospitals or community centers at unpredictable times and for unpredictable reasons. Moreover, new consequences of PTSD, and therefore new symptom patterns, may be developing. For example, information is currently emerging about how PTSD might contribute to or cause dementia.[14]

Researchers acknowledge that many other factors can affect the behavioral health of troops, such as demographics (e.g., age, gender, marital status), environment (weather, uncertain future deployment), expectations about the length of the war and the soldier's role (e.g., combat, noncombat, reserve, active), experience in different segments of the military operation, and time of return to civilian life. The Stanford study noted that because waivers of enlistment standards are increasing and pre-combat training for recent army recruits is decreasing (allowing more recruits with personal problems to enlist), more recent recruits may be more vulnerable to PTSD than those surveyed earlier. The researchers also observed that, for unknown reasons, members of the Army Reserve and the National Guard accounted for more than half of the suicides among Iraq War veterans to date, a startling figure because these groups represented considerably less than half of the total forces deployed in that theater.[15] This study is a valuable contribution to the understanding of PTSD and psychiatry's capacity to predict how many veterans of these wars are likely to suffer from the disorder.

BARRIERS TO MENTAL HEALTH CARE FOR VETERANS

A 2008 Pentagon investigation turned up several well-known barriers that discourage soldiers and veterans from obtaining the mental health care they need. They include the heightened stigma within the military against seeking help from mental health providers, poor access to military providers and facilities, and disruption in care when soldiers are transferred. Despite efforts to reduce the stigma, it remains pervasive and prevents many soldiers and veterans from seeking care. The Pentagon report found that the procedures in place were not adequate to overcome the stigma.[16] Another study reported that half of the subject-soldiers believed that seeking mental health care would harm their

careers and that more than 60 percent believed they would be viewed and treated less favorably by their leaders and unit members.[17] This barrier appears to be attributable to the failure to change attitudes and practices within the military.

In addition, treatment facilities are incapable of providing adequate care, especially in view of increased need. Shortages exist in numbers of active-duty and other mental health care professionals within the services. The Pentagon task force report indicated insufficient continuity of care, gaps in service, inadequate treatment plans, inadequate monitoring of patients, and insufficient help to family members. Without sufficient monitoring, service members can terminate treatment unnoticed.[18] This barrier is attributable to poor funding of the military's mental health service. Mental health monitoring and treatment do not have sufficient priority among other military services to be better funded.

Another barrier has a *Catch-22* dimension to it. The government can deny VA health-care benefits to soldiers who have preexisting mental health conditions or who were discharged on less-than-honorable terms. When veterans who suffer from PTSD are diagnosed with personality disorders, they become ineligible for mental health care beneffts. To be eligible, they must show that their prior existing conditions were aggravated or made worse by military service, a difficult burden. Moreover, episodes of poor behavior, such as drinking or drug abuse, resulting in punishment can result in discharge on a less-than-honorable basis. When that happens, the veterans may lose benefits for combat stress—even though such behavior commonly accompanies or results from PTSD.[19] The federal government has passed legislation and implemented programs to deal with veterans issues since the Afghanistan and Iraq Wars began. One example is the Veterans' Mental Health and Other Care Improvements Act of 2008 (Veterans' Mental Health Act).[20] Before the Veterans' Mental Health Act, in 2007 Congress passed the National Defense Authorization Act for Fiscal Year 2008.[21] The federal government has also conducted studies on the problem of military mental health care, including the Pentagon task force report discussed previously, that have revealed barriers to professional care, such as the stigma of seeking help for mental health problems.[22]

ESCALATING MILITARY SUICIDE RATES

The increasing rates of military suicides are receiving extensive attention, not only from the media, but also from the military. Because PTSD is seen as an important factor in military suicide, most authorities view the escalating suicide rate as a sign of pervasive inadequacy in dealing with PTSD problems.[23] If any lingering doubts exist about the authenticity of PTSD as defined in the *DSM*, the statistics on military suicides constitute hard evidence of emotional and mental distress resulting from military service during wartime and its destructive role. Despite variations in the studies, universal agreement exists that the number of suicides has steadily grown since 2001 to a shocking and unacceptable level.

The annual army suicide rate, which is viewed by some experts as an indicator of the prevalence of PTSD, has more than doubled since 2001, culminating in a thirty-year high in 2008.[24] The number of suicides among active-duty soldiers in the army in 2009 was 160, exceeding the record total of 140 in 2008. The total was only seventy-seven in 2003. During June 2010, the monthly total of army suicides hit a record high of thirty-two.[25]

From the invasion of Afghanistan in October 2001 until the summer of 2009, the U.S. Army lost 761 soldiers in combat. During the same period, a higher number of U.S. soldiers—817—died by taking their own lives. According to one military source, the surge in suicides is a vexing problem that baffles and frustrates army officials despite "deploying hundreds of mental-health experts and investing millions of dollars." According to an army spokesperson, one-third of the suicides were committed by soldiers who had not been deployed, renewing uncertainty about the causal relationship between the suicides and combat experience. Significantly, army leaders report that "broken personal relationships seem to be the most common thread linking suicides."[26]

Research indicates that it may take as many as three years for a soldier to recover from the stress of a one-year combat assignment. One psychologist observed that the military is in a dilemma: "'We train our warriors to use controlled violence and aggression, to suppress strong emotional reactions in the face of adversity, to tolerate physical and emotional pain and to overcome the fear of injury and death. . . . These qualities are also associated with increased risk for suicide.' Such conditioning cannot be dulled 'without negatively affecting the fighting capacity of our military.'"[27] In a special Pentagon report released in 2010, the military asserted that nearly four-fifths of army suicides were committed by soldiers who had been deployed one time, thus casting doubt on multiple deployments as the prime factor. The report placed blame on a lowering

of recruiting and retention standards plus failure of commanders to recognize or heed their soldiers' high-risk behavior. As to the first factor, the pace of deployments has forced an increased number of enlistment waivers that would have kept people out of the service and misconduct waivers that would have forced soldiers to leave service. The report also found that 60 percent of suicides were committed during the first enlistment period, usually four years. Significantly, the soldier who typically commits suicide is "possibly married, couple of kids, lost his job, no health care insurance, possibly a single parent."[28] Because so many Iraq and Afghanistan veterans fit this profile, this is a serious societal problem.

Although the surge in suicides began to garner attention in the media in 2006, an article in the *New York Times* in August 2009 ignited public discussion and provoked a response from the military, the National Center of PTSD, the National Institutes of Health (NIH), and mental health organizations. The article focused on the stories of four veterans from the 145th Transportation Company who committed suicide after returning home.[29] In their responses, the NIH and the army reminded the public that in 2008 they had initiated a five-year study of mental illness in the army titled the "Study to Assess Risk and Resilience in Service Members" (STARRS). That study is planning to cover depression, anxiety disorders, and PTSD in addition to suicide.[30]

TWO WATERSHED EVENTS: SEPTEMBER 11 AND PORTER V. McCOLLUM

Two events connected with the wars in Afghanistan and Iraq heightened the American public's awareness of PTSD. The first was the September 11, 2001, attacks on the World Trade Center and the Pentagon, which led to the invasion of Afghanistan. Not only has PTSD been acknowledged as a cause of mental distress of many victims who survived the attacks, but it also affected the workers and volunteers who participated in the response efforts. Numerous studies were conducted in the years following the attacks. In one study with nearly 12,000 participants, 51 percent met threshold criteria that warranted a clinical mental health examination. A subset of the participants was closely examined, and 13 percent of that subset met full PTSD diagnostic criteria.[31] Although actual numbers are not clear, one study showed that 12.4 percent of the rescue and recovery workers aided victims on 9/11 suffered from PTSD. So did 6.29 percent of the police officers and 21.1 percent of the unaffiliated volunteers.[32] Those would be high percentages by themselves, but they do not take into account the surviving victims at all levels of exposure, including those who escaped the buildings.

The importance, for my purposes, of these studies and media accounts is that they heightened awareness of PTSD among the general public. Since all Americans shared the shock and horror of the events, they hardly doubted the fact that huge numbers of victims and rescue workers were traumatized and eventually suffered from PTSD. If PTSD had any more ground to cover as far as public awareness and acceptance were concerned, it gained the necessary exposure during the events and aftermath of the September 11 attacks.

The second event was in November 2009, when the U.S. Supreme Court decided the case of *Porter v. McCollum*.[33] *McCollum* was an appeal of a decision on a habeas corpus petition in which a Korean War veteran challenged his confinement in prison. After George Porter, a Korean War veteran, was convicted of murder and sentenced to death in Florida, he sought habeas corpus relief in the state courts, alleging that his attorney had provided ineffective assistance in failing to raise as mitigating evidence his outstanding war record and his PTSD at sentencing. Failing to obtain relief, Porter turned to the federal courts. The District Court's grant of relief was reversed by the Eleventh Circuit. The U.S. Supreme Court reversed, concluding that the sentencing decision should have taken account of the PTSD that Porter claimed occurred because of his war service. The Court noted that combat service had traumatized and changed the veteran. Although the Court did not rule on PTSD as a defense of the crime but only as mitigating evidence in sentencing, the case is significant because it represents a pronouncement from the high court that PTSD is a valid disorder and a crucial factor to take into account during the judicial process—even based on war experience that took place decades earlier. That PTSD contributed largely to the U.S. Supreme Court's reversal of a sentence for murder lends the disorder legitimacy.

Never before in history has such extensive and in-depth information about a psychiatric disorder been within the grasp of every individual who has access to the media. Not only is every member of the military familiar with PTSD, the general public knows about it as well. However, many problems continue to exist with effective prevention and treatment. They include the failure to eliminate MST and substance abuse from the military, inadequate preparation

for transition to civilian life, continued political reliance on military action without taking into account the huge and predictable toll of both mental health and physical casualties, and the stigma of disclosing mental health problems within the military.[34]

A PERFECT STORM: PTSD IN IRAQ AND AFGHANISTAN

What insight can we gain about current PTSD problems by applying the criteria that David Grossman used to assess the Vietnam War to the Iraq and Afghanistan Wars? As for group leadership and morale, the present picture is considerably more favorable than in Vietnam. In America's all-volunteer army, troops are deployed in regular army or reserve units that have trained together. Soldiers in general are older than those drafted for Vietnam, and many reservists are older still. Young members of the armed forces in these wars have an ample supply of mature men and women as leaders and role models.

Ambiguity prevails concerning adherence to traditional codes and conventions of war. Soldiers in Iraq and Afghanistan face similar difficulties as the Vietnam forces did in distinguishing combatants from civilians. In Afghanistan, the Taliban combatants are part of the civilian population, and after attacking, they disappear into the civilian population of towns and villages. The need to scrutinize civilians as potential enemy combatants is significant. As to the third feature, the present U.S. forces operate in an environment in which potential hazards are everywhere and combat exposure is virtually unlimited. The new methods of insurgency warfare rely heavily on roadside bombs and rocket-propelled grenades (RPGs), discharged by civilians as well as combatants.

Today's veterans may not be better off than Vietnam veterans were with regard to the fourth factor, orderly transition home after a successful campaign. Multiple deployments cause considerable stress. Each deployment brings a new disruption and prevents normal life from resuming. Although troops are well received within their communities, the public tends to be generally disengaged from the war effort. Polls taken in 2011 indicate that the public is weary of the war and impatient about delay in bringing it to an end.[35] The reentry of veterans is complicated by the personal economic and employment problems that plague many Americans.

Many factors, including increased firepower on all sides; protracted duration of the war; pace of deployments, including multiple deployments; and the

constant exposure of nearly all troops to combat conditions, contribute to escalating rates of PTSD. Other factors that contribute are the leadership's unclear or shifting objectives, increased survival rates after injury because of advances in medical technology, difficulties in identifying enemy combatants from noncombatants, and shaky public support at home, along with economic and social obstacles to smooth transitions to civilian life. The fact remains that the features of war itself—including displacement from home, morally conflicting duties and their consequences, risk and anxiety, sleeplessness, and witnessing devastating injuries and deaths—cause mental stress to rise to the breaking point in many individuals.

No amount of screening, conditioning, or resilience training will eliminate psychiatric casualties. Certain measures will help maintain the fighting forces and treatment may lessen its impact, but there is no ultimate panacea for war's toxic impact on the human soul and body. This discussion provides a backdrop for examination of criminal cases involving veterans of Iraq and Afghanistan.