Another Emerging "Storm": Iraq and Afghanistan Veterans with PTSD in The Criminal Justice System

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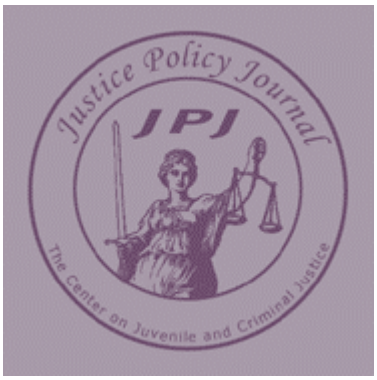

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Abstract

America seems to have moved to a position in history where we are captivated with thoughts of military power. Not since World War II has America been engaged in combat along two theaters of combat operation – Iraq and Afghanistan. We now have extended our military prowess and declared war against global terrorism, which means the number of potential combat front lines is impossible to determine. The initial blowback from such a strategy seems to be an economic catastrophe at home. This article focuses on another potential blowback – an emerging storm that encompasses the war at home that Afghanistan and Iraq Veterans are beginning to experience. The lessons from the aftermath of the Vietnam are available for all to review. A disinterest acknowledging those lessons seems to be prevailing. This article is written as evidence for the men and women who serve, or have served, in Afghanistan and Iraq that they have support for their second war – the war that begins when they leave the military. This article also challenges researchers and service providers to begin preparation to support these veterans.

About the Author

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Introduction: The Foundation of the Aftermath of War

Over thirty-five years ago the Vietnam War ended for the majority Americans. Most of the troops had returned home by 1973. Many veterans confronted a variety of social and psychological challenges. Following that war thousands of Vietnam veterans were diagnosed with PTSD (Posttraumatic Stress Disorder), while many others battled with symptoms of PTSD but never received formal diagnoses. The actual number of Vietnam veterans who developed PTSD is imprecise.

One consistency does exist in the volumes of research that focused on PTSD and Vietnam veterans – those who experienced combat were more likely to exhibit symptoms of PTSD compared to those who did not encounter combat-related incidents. Those who experienced combat can further be subdivided into categories contingent upon their combat roles – the reactive role and the initiative role. The "grunt" (foot soldier) was placed in a reactive combat role compared to the helicopter pilot who was in a position to initiate and control his combat role. Both roles involved the risk of serious injury or death. The grunt was placed on the ground to confront the enemy in an environment that often produced surprise ambush attacks from the enemy - The confrontation between opposing sides could be measured in feet. The helicopter pilot fired at the enemy below with rockets and machine guns. The confrontation between opposing sides could be measured in hundreds of feet. There is a tremendous distinction between viewing the aftermath of a battle from a distance, compared to viewing from a position where the sight of dismembered bodies, the smell and taste of death, and the frequent touching of corpses are routine.

The most common symptoms shared by Vietnam veterans with PTSD include (1) feelings

of guilt that often turned to self-punishment, (2) feeling as though they were scapegoats and/or victims of betrayal by country and government, (3) experiencing rage aimed at discriminate and indiscriminate targets, (4) psychic numbing or emotional shutdown, (5) alienation from themselves and others, and (6) doubt in their ability to love or trust others (Emerson 1976; Figley 1978; Kelly 1985; Marrs 1985; Scurfield 2004).

Many Vietnam veterans committed suicide. Similar to the data reflecting Vietnam veterans with PTSD, the actual numbers of veteran suicides are impossible to determine. Perhaps the data were perceived to be embarrassing. Perhaps we wanted to put the war behind us. Perhaps we were simply too busy with other things. Regardless of the reason, consistent incident evaluation procedures and clarified definitions of veteran suicides were not adopted. Some argue that from 50,000 to 150,000 Vietnam veterans committed suicide (Dean 2000). Those who worked at veteran organizations providing services to veterans (e. g., Vietnam Outreach Centers) knew that the number of Vietnam veteran suicides was high. Shad Meshad, a psychiatric social worker, Vietnam veteran, and one of the founders of the Vietnam Outreach Centers, discussed his early work with Vietnam veterans, "I buried eighteen people, five of them from cancer … The others, thirteen of them, were suicides. It has been this intense right from the beginning" (Mesahd 1982: 240). In the 1970s and early 1980s most programs that offered services to Vietnam veterans were completely out of touch with the needs and problems of combat veterans. Many Vietnam veterans refused to go to the VA for help or treatment (Scurfield 2004). Many veterans who did go the VA wished they had not (Klein 1981).

Many Vietnam veterans found themselves captives within the criminal justice system. Some research concludes that combat veterans have been arrested at nearly twice the rate of nonveterans who were of the same age group. In the 1980s the Veteran's Administration

concluded that the more combat exposure experienced by the veteran the more likely he would be arrested or convicted (New York Times 1982).

During the 1980s, many veterans found themselves in situations where they did not have a permanent place to live. Many were homeless – arguably, a situation that enhanced the likelihood of being subjected to eventual criminal justice system processing. The most recent survey data show that forty-seven percent of all homeless veterans served during the Vietnam War era (The National Coalition of Homeless Veterans 2008). The U.S. Department of Veterans Affairs (2008) states that nearly one-third of all homeless people are veterans, and estimate the number of homeless veterans on any given night to be 154,000. Other research on homeless veterans will reflect different statistics and will be discussed below. Before one digests the Department of Veterans Affairs' estimate, she or he must consider that a senior operative within this agency recommended that PTSD diagnoses be restricted due to limited evaluation time (CBS News 2008).

Many Vietnam veterans engaged in the practice of self-medication to reduce their PTSD symptoms – using alcohol and other drugs – which also increased their chances of being processed through the criminal justice system. As many as 75 percent of male Vietnam combat veterans with lifetime PTSD had high levels of alcohol abuse or dependence, and among Vietnam theater veteran women – as opposed to Vietnam era veteran women – alcohol abuse or dependence was among the most prevalent frequently occurring lifetime disorders (Kulka et al. 1990).

The Vietnam War has had a significant impact on families where a family member is a veteran who has PTSD. Many families have been forced to learn new survival skills as veterans with PTSD struggled with their readjustment process (Matsakis 1988). Data from the National

Vietnam Veterans Readjustment Study, arguably one of the few *comprehensive* studies of Vietnam veterans, examined family relationships of Vietnam veterans. Vietnam veterans who served in Vietnam and had PTSD reported significantly more marital problems than veterans without PTSD. Over 50 percent of the female Vietnam veterans with PTSD reported severe marital problems. Only 10 percent of the female veterans without PTSD reported severe marital problems. Episodes of family violence were more prevalent in families where the veteran had PTSD. Some of the male veterans reported that there had been 13 or more acts of family violence within the past year. Female veterans with PTSD reported much higher levels of family violence than female veteran who did not have PTSD. Finally, children in families where the father was a Vietnam veteran with PTSD had significantly more behavioral problems compared to children in families where the veteran father did not have PTSD. The number of PTSD diagnosed female veterans who had children was so minimal the data were not included for analysis (Kulka et al. 1990).

The criminal justice system is just one of many institutions that will likely be given the task of resolving problems confronting Afghanistan and Iraq veterans. At present, most criminal justice agencies do not collect or maintain data that identifies the veteran status of individuals they process. There are two primary explanations for the absence of veteran status data on arrest, booking, and court-processing records. Based on recent interviews that I have conducted, most criminal justice officials (e.g., sheriffs, jail commanders, and judges) who manage jails, prisons, and courts argue that veteran status information is not a critical factor in the day-to-day operation of their jails or courts. One criminal justice executive I talked with said that data reflecting the number of Afghanistan and Iraq veterans who become caught up in the criminal justice system might be politically damaging. The interviewee stated, “Revealing such data might contradict

the political and popularized "we support the troops" slogans and rhetoric."[1] Nevertheless, without criminal justice agencies agreeing to allow data collection of veterans processed it will be nearly impossible to develop veteran support structures.

This article draws attention to the need for research and services that address immediate problems faced by Afghanistan and Iraq veterans, their families, and their significant others, who currently find themselves, or may find themselves in the future, entwined within the criminal justice system processes. Veterans must be the principal focal point of this research and needed services. Without a comprehensive understanding of veterans, and services to address the psychological and social factors affecting their efforts to re-integrate back into mainstream society, criminal justice policies will likely continue promoting a reactive approach rather than a proactive approach to criminal/deviant behaviors. Such a strategy generally ignores the opportunity or the possibility of instituting preventive policy measures. A reactive approach typically fosters the promotion and justification for punitive policy measures as the principal social strategy to address criminal/deviant behaviors. The punitive approach prevailed in the aftermath of the Vietnam War, which was largely due to an incomprehensive understanding of, or national interest in, the effects of war on veterans.

In addition to the typical psychological and sociological factors effecting veterans returning home with PTSD, this article includes the often-ignored roles of the military as a *total institution* and military training as consequential factors in the veteran's re-entry into mainstream society in the aftermath of war – particularly in cases where veterans have PTSD. Solutions to ongoing Afghanistan and Iraq veteran problems, such as dynamic risk management approaches –

[1] Several criminal justice executives were interviewed - sheriffs, judges, and jail commanders. All agreed to answer questions related to data collection processes that focused on veteran status. All participants agreed to respond on condition that anonymity would be respected – those requests for anonymity are respected.

as opposed to risk assessment – that can be employed in criminal justice settings, will also be addressed.

Complexity of the Problem

Today, many problems confront Afghanistan and Iraq veterans in American society. Unemployment, homelessness, and a shortage of services are a few of those problems. These problems are aggravated by a downward spiraling economic environment that exhibits record-breaking home foreclosures, high rates of bankruptcy, rising unemployment rates, decline in employment opportunities, stagnant or declining middle- working-class income levels, rising costs in health insurance, and record-breaking government deficits. One might legitimately make the argument: "These are problems facing most Americans today. So, what is so special about veterans facing these same problems?" Many Afghanistan and Iraq veterans have been diagnosed, or exhibit symptoms of PTSD – an artifact of their experiences in war. ***That*** is the difference.

Many who are not veterans often respond to issues related to veterans with PTSD by asking, "Why don't they just get over it?" Prosecutors often allude to the core of this question when prosecuting a veteran who is a criminal defendant in the courtroom setting – virtually ignoring the affect of war trauma in exchange for a politically correct and expedient guilty verdict and/or a harsh sentence.

Distinct from those who have never served in military service or served in a war zone, veterans who served in war zones, and mainly those who have served in combat situations, often experience two wars. Their first war was in the government-recognized war zone. Their second war began when they returned home from the first war (Emerson 1976; Meshad 1982; Scurfield 2006; Schroder and Dawe 2007). The length of time they spent in the first war was generally much shorter than the ongoing war they find themselves in at home. The second war is

prolonged and often amplified through their recollection of previous experiences triggered through their five senses (Figley 1978; Kelly 1985; Scurfield 2006). In the ongoing Afghanistan and Iraq wars, the likelihood of returning veterans experiencing posttraumatic stress disorder, now often amplified by traumatic brain injury, is potentially extreme – particularly when one considers the redeployment and stop loss practices that subject these veterans to multiple tours in Afghanistan and Iraq.[2]

Considering the experiences of the most recent group of veterans today, there are several important distinctions between issues surrounding Vietnam veterans and today's Afghanistan and Iraq veterans. Today, military personnel are more likely to have served multiple tours in Iraq and/or Afghanistan compared to the typical single-tour that troops served during the Vietnam War. Over 1.5 million service men and women have served in Afghanistan and Iraq since 2002. Some high-ranking military officials indicate that existing deployment data demonstrate a significant burden has been placed upon the U.S. military. For example, General George Casey, the Chief of Staff of the United State Army, stated, "The demand for our forces exceeds the sustainable supply" (Baldor 2007). General Peter Pace, the former Chairman of the Joint Chiefs of Staff, contends that the penalty of over extending the military have grim potential strategic consequences (Korb 2007). The number of military personnel who have served multiple tours in Afghanistan and Iraq is staggering. Nearly one-third (450,000) of the military personnel who have been to Afghanistan and/or Iraq have been deployed more than once. Twenty U.S. Army brigades have served two tours in Iraq. Nine brigades have served three tours, and two brigades have served four tours (Korb, Rundlet, Bergman, Duggan, and Juul. 2007). Approximately

[2] Stop Loss is an involuntary extension of service, contained in the military service member's enlistment contract that allows the military to retain the individual beyond his or her initial end of term of service (ETS) date.

20,000 members of the U.S. Army have been deployed five or more times (U.S. Department of Defense Task Force on Mental Health 2007).

Today, many Afghanistan and Iraq military personnel have had their ETS (Estimated Time in Service) extended due to the stop-loss clause in their enlistment contract (Washington Post 2004). In 2004, according to Lt. General Franklin L. Hagenback, the U.S. Army's deputy chief of staff of human resources and personnel supported the "stop-loss" policy because it reduces the normal attrition of troops and prevents divisions from seeking additional troops when they go to Iraq or Afghanistan. Congress authorized such measures after the Vietnam War. Stop loss was initially employed during preparations for the Persian Gulf War in 1990, and has since been used to strengthen divisions going to Iraq and Afghanistan (Washington Post 2004). The U.S. military has kept 70,000 military personnel beyond their scheduled discharge date through the stop-loss policy (Korb, et al. 2007), and 8,000 of those personnel currently remain on active duty (American Psychological Association 2007).

Exasperating the problems confronting young veterans today is the absence of a comprehensive understanding of the impact of war on those who have served in war zones. This lack of understanding seems to exist throughout much of America – even though we have volumes of research and personal accountings in the aftermath of the Vietnam War. This is particularly true in the case of the American criminal justice system. American history seems to be positioning itself for a replication of the imprudent responses to veterans' experiences and needs practiced for at least the past several decades.

The War that Never Ends: Posttraumatic Stress Disorder

According to the Diagnostic and Statistical Manual of Mental disorders (DSM-IV-TR), Posttraumatic Stress Disorder is

The development of characteristic symptoms following exposure to an extreme traumatic

> stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror…The characteristic symptoms resulting from the extreme exposure to the extreme trauma include persistent re-experiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C) and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F) (DSM-IV-TR 2000).

Although the criteria for diagnosing PTSD are clearly defined in DSM IV, PTSD remains an ongoing problem for veterans of all eras, and for many of their families. The problem does not rest in the definition; rather it lies in the response and treatment of PTSD. One noteworthy problem associated with PTSD is the fact that it is often like a light switch. At times it seems as though the veteran is well on the way to resolving her or his problem, but a single incident or event can take the individual back to the point of origin. In most instances, the veteran does not perpetuate the incident or event that ignites PTSD symptoms. Current Images and reports from Afghanistan and Iraq serves as a trigger for many older veterans (WWII, Korea, Vietnam, Gulf War I) to experience recurring PTSD symptoms from their own combat experiences (Brown 2005; Schroder and Dawe 2007). Shad Meshad, Executive Director of the National Veterans Foundation (NVF) in Los Angeles, California, indicates that veterans from past wars are experiencing significant increases in stress as images and information of the ongoing wars in Afghanistan and Iraq is injected into mainstream America. Following the release of the film "Saving Private Ryan," telephone calls from World War II veterans flooded the suicide toll-free phone banks at the NVF, revealing that the first few minutes of the film brought back horrific memories of their previous combat experiences (Shad Meshad interview 2008).

The National Center for PTSD (2008) estimates that one of every 20 WW II veterans

has suffered symptoms such as bad dreams, irritability, and flashbacks. A Korean War researcher has claimed that as many as 30% of US troops who fought in Korea, and are still alive today, may have symptoms of PTSD (Epstein 2005). More than 30% of Vietnam Veterans (more than 1 million) have suffered from symptoms of PTSD (Kukla et al. 1990).

The U.S. Department of Veterans Affairs Fifth Annual Report (2007) suggests at least 30 to 40 percent of Iraq veterans will face serious psychological problems associated with PTSD. Major General James T. Conway argues that multiple tours without adequate time at home between tours of duty in combat areas increases the rate of combat stress by 50 percent (Conway 2007).

According to Iraq-Afghanistan Veterans of America (IAVA), more than 78,000 veterans have sought help for mental health related issues (IAVA 2007). Military personnel—both active duty and reservists—were found to be more likely to report substance abuse, family problems, and symptoms of PTSD 6 months following their return – significantly higher than reports indicate during post-deployment health screenings offered by the military (Waters 2007). According to data revealed in the Mental Health Advisory Team (MHAT) IV Final report (2006) over one-half of the soldiers and Marines in Iraq who tested positive for a psychological injury expressed concern that their fellow service members would perceive them as week. Nearly one-third were concerned about the effect of a mental health diagnosis on their career. This report also demonstrates that 20 percent of married military personnel in Iraq were found to be preparing for divorce, about 40,000 Iraq and Afghanistan veterans have been treated for substance abuse at VA hospitals, and since the beginning of both wars, there have been 147 recognized suicides **in Iraq** – noting that the current U.S. Army suicide rate is at its highest level in 26 years (MHAT 2006). In May of 2007, the DVA reported that upwards of 1,000 veterans in

their care commit suicide each year. According U.S. Rep. Jim Moran, who introduced the Josh Omvig Veterans Suicide Prevention Act of 2007 (H.R. 2219), more than 115,000 veterans attempt suicide every year accounting for "only 11% of the population…(and)… nearly one in five suicide attempts in the entire United States" each year (Falls Church News Press 2007). According to a recent study in the Journal of Epidemiology and Community Health, veterans are twice as likely as non-veterans to commit suicide (Kaplan et al. 2007). A 2007 CBS investigation of veteran suicides in 45 states revealed that in 2005 more than 6,000 veterans committed suicide (CBS News 2007).

Reuters (2008) revealed an Army report that released new data that showed a significant increase in the number of military personnel who had been diagnosed with PTSD after tours of duty in Afghanistan and Iraq. The data reflected diagnoses conducted at U.S. military facilities beginning January 1, 2003 to December 31, 2007 (See Table 1).

Table 1
New Posttraumatic Stress Disorder Cases
Diagnosed at U.S. Military Facilities
(2003-2007)

	2003	**2004**	**2005**	**2006**	**2007**
Army	1,020	3,845	6,575	6,876	10,049
Marines	206	577	1,378	1,366	2,114
Navy	216	377	643	701	947
Air Force	190	298	511	606	871
Total	1,632	5,097	9,107	9,549	13,981

Thus, more than 39,000 active military personnel have been diagnosed with PTSD at U.S. military facilities – an environment that tends to label those with PTSD as weak or cowardly.

Recent interviews conducted with more than 62 Afghanistan and Iraq veterans during their discharge processing reveals that over 80 percent said they were strongly encouraged by

military personnel to check the boxes that indicated the veteran did not have any psychological symptoms that could be construed as PTSD. Some recalled being told that failing to ignore this advice would result in prolonging their discharge process. Most of the participants complied rather than risk remaining any longer at the military installation from where they were being released from active duty.[3]

Recently, a Department of Veterans Affairs (DVA) email revealed that a senior staff member at a VA hospital in Texas encouraged subordinates to engage in misdiagnosing patients with adjustment disorder and to refrain from making PTSD diagnoses because it is too expensive for the DVA (Washington Post 2008). The DVA has seen more than a tenfold increase in PTSD claims since the start of the Iraq war. According to the DVA, 48,000 Iraq and Afghanistan veterans have already been diagnosed with PTSD (Hohmann 2007).

There are volumes of psychological and psychiatric research where researchers have focused on the topic of posttraumatic stress disorder as an artifact of war. Much of this research (see below) focuses on the effects that trauma has on the individual and on his or her social support patterns.

Relationships between lower levels of social support and poorer health have been established through research (Cohen and Wills 1985). Relative to trauma-induced mental health issues, low levels of social support have been associated with elevated levels of posttraumatic stress disorder in both civilian and military communities (Davidson et al. 1991; Kaniasty and Norris 1993; Keane et al. 1985; King et al. 1998). Studies conducted with more than 2,000 Gulf War I veterans' reveals that the presence of interpersonal problems associated with PTSD may

[3] Interviews were conducted by Brown (author) in Minneapolis/St Paul, MN (August 2008) during the Veterans for Peace and Iraq Veterans Against the War Convention. Data were derived from 18 female and 42 male Afghanistan and Iraq veterans.

have an unfavorable influence on the quality and quantity of available social support resources. This author recently interviewed a counselor at a Vet Center in the Northwest. The scope of the questions centered on the number of homeless veterans with PTSD seeking assistance at vet centers. The counselor said, "Most of them are faking it." I asked if the counselor had combat experience. The counselor responded, "No, that is irrelevant."[4] It has been recommended that greater focus be placed on the interpersonal skills of those suffering from PTSD (King et al. 2006).[5]

The association between social support and PTSD can be partially accounted for by interpersonal issues that come with PTSD. Studies of veterans demonstrate that individuals with PTSD more likely harbor interpersonal problem-solving shortfalls, difficulty with intimacy and cordiality, marital distress and relationship abuse, and demonstrate difficulties in parenting (Beckham et al. 1996; Jordon et al. 1992; Roberts et al. 1982; Ruscio et al. 2002; Solomon and Mikulincer 1987). Byrne and Riggs (1996) pointed out that many symptoms of PTSD directly point to interpersonal difficulties, evidenced by feelings of detachment from others as well as angry outbursts.

A recent article in the *Journal of the American Medical Association* reported that 35% of Iraq Veterans have already sought help for mental health concerns. The study noted that 60 percent of veterans who screened positive for PTSD did not seek treatment. More alarming, only 20 percent of those who screened positive were referred to treatment. Of those who accessed mental health care within one year after deployment, only 7.6 percent actually had a referral

[4] Interview was conducted in 2007. The counselor was guaranteed confidentiality before the interview began.

[5] Given the insensitivity of this counselor's remarks and the more general view of the military concerning this issue, perhaps more emphasis should be directed to the interpersonal skills of those who are placed in positions to administer social support.

(Hoge et al. 2006).

A 2004 *New England Journal of Medicine* Study found that more than 60% of OIF/OEF (Operation Iraqi Freedom/Operation Enduring Freedom) veterans showing symptoms of PTSD were unlikely to seek help due to fears of stigmatization or loss of career advancement opportunities (Friedman 2004). In 2005, the DVA reported that 18% of Afghanistan Veterans, and 20% of Iraq Veterans in their care were suffering from some type of service connected psychological disorder.

A wide variety of today's veterans have been exposed to combat and traumatic experiences (e.g., infantrymen, medics, scouts, clerks and other rear echelon personnel). It is important to note that since 2003, the combat zone in Iraq includes the entire country – there are limited "rear areas." The number of Afghanistan and Iraq female veterans who have experienced combat far exceed the number of female Vietnam veterans who had combat exposure – e.g., nurses who served in medical facilities in combat zones throughout Vietnam (Van Devanter 1983). Currently, very little data exist that focuses on the problems confronting young female veterans. Hopefully, researchers will not wait decades, like criminologists did in their inquiry into female criminality, before the problems confronting these remarkable female veterans become of interest to researchers. Today, the percentage of military personnel returning home with PTSD appears staggering, and suicide rates among young veterans suggest a potential veteran suicide epidemic.

In order to fully understand the complexities associated with a veteran's risk for chronic mental health problems (e.g., PTSD) it is necessary to consider the role and function of military training and the total institution (an area that has enjoyed research immunity in the area of PTSD), contributing static variables, and the more opaque dynamic variables, which include the

psychological "software" installation and manipulation procedures employed during the training processes in the military total institution.

The Military Total Institution and Military Training

Previous research has addressed the issue of the military as a *total institution*. For example, Bamberger and Hasgall (1995) addressed the instructor's role in education and training in military settings, and Zurcher (2007) examined the process of assimilation into the military through training. However, the military as a total institution has not been examined relative to the problems confronting veterans as they negotiate their reentry process into mainstream society. Following release from military service many veterans experience a "software" problem – the "software" that was installed while they were in the military often does not work in a civilian landscape. Human beings develop a mental process that assists in them in making decisions that typically result in responses to a variety of social stimuli. This process is constructed as they learn social customs, values, and beliefs. Killing another human being, for example, is considered an unnatural act in the civilian environment. In the military, killing is viewed differently – killing becomes a more natural act that enhances the likelihood of survival and advances the probability that the military will succeed in its mission. When civilians are inducted into the military it is imperative that their thought processes be converted to facilitate the needs of the military. Acceptable civilian principles are not necessarily beneficial to the military. Conversely, a good soldier's principles, created in the military total institution, are not necessarily acceptable or advantageous in mainstream society.

The United States military system meets many of the criteria set forth in Goffman's *total institution* model (Goffman 1961). The individual's entire being is devoured and controlled in a total institution environment. This environment undercuts the person's individuality, disregards the individual's dignity, and results in a regimentation of life that typically disregards his or her

desires or inclinations. Short of going AWOL (Absent Without Leave) or desertion, the total institution significantly restricts the options for military personnel until their contractual agreement expires (discharge) – or until she or he is dead.

There are varying degrees of regimentation, esprit de corps, discipline, and institutional expectations among the branches of the military, as well as between various M.O.S. (Military Occupational Specialties) classifications within individual branches of the military. Often, these distinctions foster competition among the different branches of service and various types of units within an individual branch of the military service. It is generally accepted by the public that the United States Marine Corps is the "toughest" among the different branches of military service. However, U.S. Army Rangers or members of the Special Forces would oppose that claim. U.S. Navy Seals might laugh or take issue at such a claim from both of these branches of service. In the U.S. Army, airborne qualified soldiers are encouraged to trivialize soldiers who are not airborne qualified – Non-airborne qualified personnel are referred to as "legs." This bickering among branches, units, and various M.O.S. classification groups, fosters competition within the total institution. Competition promotes the rationale and goals of the United States Military system. The ultimate goal of the U.S. military is to defeat the enemy (competition) – to win.

Several concepts are germane to the military total institution. Subscription to, and compliance with, these concepts is crucial for the success of the socialization process of into the military. First, there is ***obedience***, which is submissiveness to the command of authority. Obedience is measured by the degree of willingness to obey orders, and enables officers and non-commissioned officers to carry out their assigned missions. Without obedient subordinates, officers and non-commissioned officers would be unable to demonstrate their own levels of obedience.

The second concept is ***discipline***, which is necessary to correct, mold, or perfect the mental faculties or moral character of an individual. Typically, the higher the level of obedience results in a higher level of discipline. Without a high level of discipline, military personnel in critical situations would have difficulty surviving or successfully completing their assigned missions. Endless and repetitive training, until the trainee's reaction becomes second nature, produces high levels of discipline (See Caputo 1977).

The third concept is ***survival***. Survival, in simplistic terms, is the means and commitment to facilitate the continuation of life or existence. In the military, and particularly for those military personnel who are in or attached to the combat units, survival requires subscription to and adoption of the "by any means necessary" philosophy. Soldiers unable to survive can no longer provide support to their fellow-soldiers. Survival is not limited to benefit only the individual. Survival enhances the survival of the individual's military brothers and sisters. Ultimately, survival insures the success of the mission – the primary goal of the military total institution.

The final concept is ***sacrifice***, which requires the forfeiture of something valuable for the sake of something else. During the training processes military personnel are required to sacrifice their individuality. However, in combat or catastrophic situations the total institution, through its process of socialization, prepares military personnel to make the ultimate sacrifice – their own lives. In many training scenarios the sacrifice of one's life is portrayed as honorable.

In preparation for the ultimate challenge, which is war, the United States Military establishes a series of ***benchmarks***, which must be met and maintained. Established benchmarks are based on prior experiences and perceived or anticipated future events. Meeting and maintaining those benchmarks are measured at various intervals of the selection and training

processes. The ultimate goal for the United States Military in a period of war is to defeat the enemy and win or be victorious.

The goal of the selection process is to seek out recruits who are most likely to adopt the philosophy and carry out the prescribed mission, in the shortest period, of the total institution. However, in a time of war or conflict, reality requires the induction of many who demonstrate less than complete willingness to adopt the institution's philosophy.

The ultimate goal of the training process is to produce military personnel who will respond to orders without question, and perform their duties in a manner that can only be described as exemplary. This is accomplished through continuous repetition of the training subject matter. Those who excel during their training process are more likely to be introduced to advanced training. Those who simply meet the basic criteria of the training, or those who do not desire to go to more advanced training, are prone to continuation or repetition of their assigned roles. The more training received by a member of the military, the more likely that member will respond automatically in a real-life situation.

The length of service, and the level and extent of training, coupled with the recruit's level of cooperation with staff, often determines the degree of success attained by the staff. The socialization process into the military can bring about considerable change in an individual during their transition from civilian to airman, seaman, soldier, or marine. However, the level of success depends largely on the recruit's willingness or appetite to accept the customs, values, and beliefs without hesitation. The more willing each individual is to participate in the military's re-

socialization process, which includes excelling in initial training and/or advanced training curriculums, the more likely the total institution will be successful.[6]

Weapons' training is a primary function of the military. Weapons' training is provided for both defensive and offensive responses. For those trained extensively in the use of weapons, the more likely the weapon will used instantaneously in a time of peril (Grossman 1995). For many who excel at weapons training, resorting to the use of a weapon is similar to the professional table tennis player who automatically reacts when an opponent hits the ball.

Grossman (1995) found that the ability and willingness to fire a weapon at an enemy soldier by military personnel has escalated over the years. He began his analysis with Marshall's research of soldiers in World War II, where research found that soldiers fired their weapons at the enemy at a rate of 15-20 percent (Marshall 1947). That rate increased to 55 percent during the Korean War, and increased to 90-95 percent during the Vietnam War. Grossman contends that the instruments are the same or at least similar – rifles, pistols, and automatic weapons. He argues that what has changed is the "software" programmed into the brain of the weapons operative – the soldier. The software is "installed" during the training process, and that training improves the likelihood of firing a weapon at a prescribed target – the presumed enemy. Ultimately, the willingness to kill another human being is enhanced.

Following release from the military the veteran does not experience extraction or deprogramming of the military-installed "software" referred to by Grossman. Obviously, some veterans have been successful in the deprogramming or removal/replacement of military-installed software. Others have not been so successful. Many veterans are not even aware that

[6] These conclusions are influenced by my own military experiences, of which much of that time, as a non-commissioned officer and commissioned officer, I was a U.S. Army trainer (Drill Sergeant at Ft. Lewis, Washington; U.S. Army Jump School and U.S. Army Ranger School at Ft. Benning, Georgia).

the socialization process altered their former thought mechanisms and processes. Scores of veterans often assume that being discharged from the military will have no affect on their re-entry process into mainstream society. For some veterans, this may actually be true. For others, particularly those who have experienced traumatizing events, PTSD and the remnants of their military socialization process will serve as a filter for those life experiences. Neither the military nor the Veterans Administration is planning to contact them after discharge to ask how they are doing. Instead, many are not aware of their problem until they become homeless, involved in a domestic violence situation at home, or find themselves as a defendant in the criminal justice system.

The inability to sustain meaningful relationships and controlling rage will increase the likelihood that many of these veterans will experience criminal justice confrontations. In some cases, mere apathy demonstrated by those who do not share similar past experiences could serve as a triggering mechanism for veterans with PTSD. For many veterans, past military socialization processes they have experienced will contaminate the social landscape. Veterans will be forced to make decisions. Which software program will they rely on to make their decisions? One software program provides a particular set of options, while the other software program provides a completely different set of options. The answer to the previous question is, of course, no one knows – including the veteran. There are those who will argue that risk assessment instruments can be developed to properly assess the individual and predict his or her behavior – good luck with the false positives and false negatives.

Additional Problems Confronting Afghanistan and Iraq Veterans

Unemployment, homelessness, Alcohol, Divorce, Domestic Violence, and Child Abuse are additional problems confronting Afghanistan and Iraq veterans. Each of these problems

increases the likelihood that the veteran may encounter problems within the criminal justice system. Each of these problems may be either the triggering mechanism or the result of PTSD.

Unemployment and Income: In November of 2005, The U.S. Bureau of Labor Statistics reported that for the first three quarters of 2005, nearly 15 percent of veterans aged 20-24 were jobless, which reflects a figure three times the national average. A more recent study by the U.S. Department of Labor found 11.2 percent of young veterans (18-24) were unemployed (U.S. Department of Labor 2007). In 2007 the *Associated Press* revealed that 18 percent of the veterans who searched for employment within one to three years after discharge were unemployed. One reason provided was that employers were apprehensive about the mental status of the veterans. The report also notes that 25 percent of veterans who did secure employment earned less than $21,840 per year (*Associated Press* 2007). The Office of Management and Budget stipulated that the average poverty threshold for a family of four in 2006 was $20,614; for a family of three, $16,079; for a family of two, $13,167; and for unrelated individuals, $10,294 (U.S. Department of Commerce 2007). Neither report differentiates between married and non-married veterans who secured employment. A recent study of veteran unemployment by the Rand Corporation found that young veterans are much more likely to be unemployed when compared to young non-veterans in the general population (Savych et el. 2008). A veteran may be unemployed because of an on-the-job altercation with a co-worker – perhaps induced by PTSD. A veteran may be unemployed because of economic conditions – this may amplify the sense of worthlessness or helplessness, which can trigger PTSD reactions.

Homelessness: Whereas the U.S. Department of Veteran Affairs estimated the number of homeless veterans to be 154,000 (previously noted above), a 2007 National Alliance to End Homelessness (NAEH) report estimates that 200,000 veterans are homeless on any given night,

and more than 300,000 will experience homelessness over the course of a year. Of all homeless veterans, nearly 70% suffer from drug, alcohol, or mental health problems. There are nearly 50,000 homeless veterans in California (NAEH 2007). The 2007 Annual Homeless Report to Congress identified 18.7 percent of sheltered homeless individuals as veterans (U.S. Department of Housing and Urban Development 2007). However, many veterans reject shelter options and opt for settings that offer more freedom and fewer restrictions; reasons which likely play havoc with official homeless data collection and reporting. The Swords to Plowshares Iraq Veteran Project draws attention to veterans with PTSD and/or Traumatic Brain Injury (TBI) in relationship to the potential to become homeless. The symptoms of TBI are similar to symptoms of PTSD (e.g., rage, family relationship problems, etc.) (Swords to Plowshares Iraq Veteran Project 2006). One report indicated that 65 percent of Afghanistan and Iraq vets treated at Walter Reed Hospital were diagnosed with TBI (U.S. House of Representatives 2007).

A homeless study of Marion and Polk counties in Oregon, conducted in January 2007 by this author, reveals that veterans accounted for more than 27 percent of the 360 homeless people interviewed (Brown 2007). Moreover, 30 percent of those veterans were from the Afghanistan and Iraq wars. Six of the Afghanistan and Iraq war veterans were women who were married and had children. Almost 85 percent of the homeless veterans said they had been in jail at some point, while 17 percent indicated they had spent time in prison. In July 2007, during a jail study of the Marion County jail in Salem, Oregon, also conducted by this author, identified two of the women who participated in the homeless study several months earlier – they had graduated from homeless female Afghanistan/Iraq veterans to female Afghanistan/Iraq veterans in jail. Nearly all of the homeless veteran interviews were conducted in the streets, parks, and under bridges in the two Oregon counties. Most veterans indicated they preferred to battle the weather as

opposed to staying in a homeless shelter. The majority of national homeless data is collected in shelters.

***Alcohol, Divorce, Domestic Violence, and Child Abuse*:** According to an Army Post-Deployment Reassessment Study completed in July of 2005, alcohol misuse among soldiers rose from 13% among soldiers to 21% one year after returning from Afghanistan and Iraq. The same study saw soldiers with anger and spousal aggression issues increase from 11% to 22% after deployment, and those planning to divorce their spouse rose from 9% to 15% after combat deployment (Journal of American Medical Association 2007). A study of domestic violence perpetrated by veterans with PTSD revealed that domestic violence rates were significantly higher when compared to veterans who did not have PTSD. The study found more than 80 percent of the sample committed at least one act of violence in the previous year, and almost half had committed one severe violent act (Sherman et al. 2006). The number of active-duty soldiers getting divorced has increased sharply in the aftermath of deployments to Afghanistan and Iraq. The trend is severest among officers. Last year, 3,325 Army officers' marriages ended in divorce -- up 78% from 2003, the year of the Iraq invasion, and more than 3 1/2 times the number in 2000, before the Afghanistan operation. For enlisted personnel, the 7,152 divorces last year were 28% more than in 2003 and up 53% from 2000 (USA Today 2005). The combination of these three variables (alcohol, increased anger and aggression, and divorce), equate to a potentially significant increase in domestic violence, and a greater likelihood of veterans becoming involved in the criminal justice system. A recent study reveals that incidents of child abuse involving military families either leaving or just returning from deployment had risen 30% since 2001 (Rentz et al. 2007). Another report concludes that child maltreatment among families of enlisted soldiers in the U.S. Army are higher when the soldiers are deployed, but this applies primarily to

families where the mother is present at home. The explanation for these higher rates of child maltreatment is directed to the spouse's ability to cope with stress or their ability to mobilize resources such as childcare or financial obligations (Gibbs et al. 2007).

Missing from the data presented in this article are data and estimates that show the numbers of Afghanistan and Iraq veterans who have already been arrested, prosecuted and sentenced in the criminal justice system to date – which is one of the primary motivations for writing this article. Researchers must attempt to develop collaborations with criminal justice agencies in order to produce data that reflect Afghanistan and Iraq veterans, and their families, who are draw into the criminal justice system.

Solutions and Prescriptions

Potential solutions and prescriptions are as complex as the problems raised in this article. Quick fixes or silver bullets that instantly provide relief for the subjects in this article – Afghanistan and Iraq veterans and their families – are not available. There are, however, options available that are cost effective and would certainly meet evidence-based-practices standards. Institutional, political, and social barriers would first have to be dismantled.

Afghanistan and Iraq Outreach Centers: It took roughly seven years after most of the troops returned from Vietnam to pass legislation (The Vet Center Bill: July 13, 1979) that created the Vietnam Outreach Centers. Shortly after Ronald Reagan was sworn into office in 1981, however, there was a concerted effort to close the centers and shift responsibility back to the Veterans Administration. The Veterans Administration's failure to adequately treat veterans for PTSD was the reason the Vietnam Outreach Centers were created – outside of complete control of the Veterans Administration. The principle problem that confronted the administration's attempt to close the centers, and to shift complete control of the centers back to the Veterans

Administration, was the fact that the centers had recently reported a 50 percent increase in the number of veterans coming in for their first visit. The meager $12 million appropriated to fund 92 Vet Centers throughout America became a colossal success. One of the hallmarks of the Vietnam Outreach Centers was the inclusion of Vietnam veterans who served as counselors and service providers. Service providers who assisted veterans coming onto the centers understood their language. Like many of the veterans seeking assistance, many of the counselors also had personally experienced combat in Vietnam. By the mid-1980s many Vet Centers began assisting the spouses of Vietnam veterans. The Vet Centers were eventually placed under the control of the Veterans Administration, where today they still operate.

Few existing Vet Centers have Afghanistan and Iraq veterans as counselors – the original hallmark of the Vietnam Outreach Centers. Providing counselors who share the language and experiences of their clients would mark a significant step forward in addressing many of the problems experienced by Afghanistan and Iraq Veterans and their families. Such a strategy would facilitate a preventive approach to many of the veteran problems noted above. Another advantage to this strategy would be the creation of a resource for criminal justice agencies. Vet Centers could provide services – as alternatives to current punitive approaches – for veterans going through the criminal justice system.

Dynamic Risk Management: Posttraumatic stress disorder is not a static psychological condition for many veterans. PTSD is a dynamic psychological condition that often subsides for extended periods. Many veterans who have PTSD can live relatively normal lives without demonstrating symptoms of PTSD – at least until an event occurs (e.g., a loud sudden noise, a peculiar smell, confrontation with a situation that seems irresolvable, etc.) triggers a PTSD-like response. Predicting the outcome or specific response in the aftermath of a PTSD triggered event is, at

best, problematic.

Dynamic risk management assists in the conversion from a focus on prediction to one of prevention. An effective dynamic risk management plan involves mentoring programs, education, restorative justice programs, motivational interviewing, proactive scheduling of court reviews and efficient, coordinated application of local resources. A re-arrest prevention strategy is important and compatible with diversion programs and the principles of therapeutic jurisprudence. A simple plan involving proactive monitoring can be very effective. A good example of how this can work is the mental health court that began operation in Vancouver, Washington in the year 2000.[7] Current academic literature suggests that courts can be extremely effective in promoting public safety by applying risk management strategies within the context of the problem-solving court philosophy (Wexler and Winnick 1996; Winnick and Wexler 2003). Drawing from the philosophical underpinning of problem solving courts, Greg Berman and John Feinblatt (2003) suggest that courts can:

> Seek to broaden the focus of legal proceedings, from simply adjudicating past facts and legal issues to changing the future behavior of litigants and ensuring the well-being of communities (p. 73).

The application of dynamic risk management in partnerships developed by the courts and the program previously proposed above. The blueprint to develop collaborations between the courts and the Afghanistan and Iraq Vet Center proposal can be patterned from existing partnerships between mental health courts and social service agencies.

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[7] The *Clark County Mentally Ill Re-Arrest Prevention Program, Final Report* available from Heidi Herinckx, Senior Researcher at the Regional Research Institute for Human Services, Portland State University, P.O. Box 751, Portland, OR 97207, 2003.

Conclusion

Over 1.5 million men and women have served in Afghanistan and Iraq since 2002. Approximately one-third of military personnel have served more than one tour in Afghanistan and Iraq. Nearly 20,000 members of the U.S. Army have been deployed to Afghanistan and Iraq five or more times. The military has kept 70,000 service personnel beyond their scheduled discharge date. The U.S. Department of Veterans Affairs predicts that between 30-40 percent of Iraq veterans will experience PTSD. The number of female veterans who have experienced combat far exceeds the number of female veterans from the Vietnam War who share similar experiences. Afghanistan and Iraq veterans currently experience disproportionately high unemployment rates. Homeless veteran estimates range from over 150,000 to 200,000. Alcohol misuse by Afghanistan and Iraq veterans has increased significantly. Divorce rates among this veteran population are on the rise. Domestic violence is increasing within families where one or more parents is an Afghanistan or Iraq veteran. Child abuse is increasing in families where a parent is deployed to Afghanistan or Iraq, and child maltreatment has increased in families of enlisted soldiers when the soldiers are deployed. Clearly, the data suggest that an ***emerging storm*** is approaching American society. We can begin preparation for the storm, or we can wait and see if it will pass us by. The aftermath of Vietnam and New Orleans comes to mind.

There are many veteran organizations available to offer support to Afghanistan and Iraq veterans. Veterans for Peace (http://www.veteransforpeace.org/), Iraq and Afghanistan Veterans of America (http://www.iava.org/), Iraq Veterans Against the War (http://ivaw.org/), and the National Veterans Foundation (http://www.nvf.org/) are some of the support organizations that are available to Iraq and Afghanistan veterans.

Another program, The Bunker Project (the name was provided by a group of Afghanistan and Iraq veterans at the National Veterans Foundation), an affiliate of Pacific Sentencing Initiative (http://www.pacificsentencing.com) was recently launched in Oregon and Washington. The principal goal of the Bunker Project is to assist veterans, veteran family members, and significant others associated with veterans who find themselves drawn into the criminal justice system, and to educated members of the legal system about the unique situations veterans and their families are confront with. Recently, this goal has been extended to educate law enforcement agencies in Oregon and Washington. Training sessions are provided to judges, prosecutors, defense attorneys, sheriff's offices, and departments of human services. In addition to providing information about PTSD and family issues in military and veteran families, the training curriculum also emphasizes the necessity of data collection, alternatives to punitive solutions, and responsible reactions to situations involving Afghanistan and Iraq veterans and their family members.

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