Welcome Home

A Course Reader

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How to Use This Reader

This reader has been compiled to serve as a resource for anyone wanting learn more about returning veterans and the wars in Iraq and Afghanistan.

I. The first section of the reader basic facts about veterans issues. These are designed to be used as handouts that can be photocopied and distributed at trainings.

II. The second section provides a very basic historical timeline of the Wars in Iraq and Afghanistan.

III. The third section is dedicated to data and research. Articles have been included here to give the reader a general sense of the current data on PTSD, TBI, Casualties, Suicide, Military Sexual Trauma, Employment and Homelessness in veterans. The numbers provided are not definitive and are certainly subject to becoming out of date relatively quickly. However, they provide an excellent overall picture of the current status of these topics that effect veterans.

IV. The fourth section deals with issues relating to student veterans. There are two reports which highlight specific recommendations and some interesting articles about transition issues and women veterans on campus.

V. The final section provides a small taste of writing about the war by veterans themselves.
Welcome Home

Post-Deployment Readjustment Survey

Check all that apply:

☐ As a result of my service, I feel like I have accomplished more than many of my friends and/or my family.

☐ Most people have no idea what it takes to serve in a combat zone.

☐ I see things differently now – the world, other people, myself.

☐ I am more angry or irritable than I would like to be.

☐ Driving is more stressful than it used to be.

☐ I drive too fast.

☐ When I do get angry (even if no one knows I’m angry), I stay angry for a long time.

☐ I am now less sociable than I would like to be.

☐ I don’t like to go out as much as I used to, either because I get into fights or because people make me angry (and I don’t want to get into a fight).

☐ I have a hard time relating to things that other people (wife, girlfriend, parents, friends etc…) think are problems, but I don’t think are a big deal.

☐ I sleep less than I would like to.

☐ I have a weapon (or weapons) at home.

☐ I carry a weapon in my car.

☐ I drink or smoke pot more than I used to prior to my military service.

☐ I sometimes drink or smoke pot to zone out or get numb.

☐ I often feel detached from other people.
I don’t really like going to parties that much, even though I used to.

I sometimes feel numb. At those times, I don’t feel bad, I just don’t really feel much at all.

I have mixed feelings about some of the things I saw and some of things I did while I was deployed.

My relationships have changed since I returned.

There is a lot more conflict in my relationships (arguments, bickering etc…) than there used to be.

I usually keep my thoughts to myself.

I highly doubt that others (friends & family) will understand what I’ve experienced or what I’m thinking about.

I am aware of my exits at all times.

There are times when I feel really lonely, but often don’t feel like reaching out to others.

I constantly monitor other people to see if they will be a threat to me or not.

People ask me stupid questions about the war or about my experiences.

I do not have a clear idea about what I want to do with my life.

Since I was deployed (or while I was deployed), I had a child.

Since I was deployed (or while I was deployed), I got married.

Since being deployed, I got divorced.

Since being deployed someone important to me passed away.

Since I was deployed, I changed.
Welcome home returning veterans! We are honored to have you on campus and look forward to your continued success here. For some returning veterans, going back to school can present unique challenges. If that is true for you, remember that you do not have to face these challenges on your own. We are here to help. Please feel free to discuss any questions or concerns you may have about the curriculum, the assignments, or your academic program with me in person. Thank you for your service, and welcome home!
Questions to Avoid Asking Veterans

1. Did you kill someone? What’s it like to kill?

*WHY NOT TO ASK:* This is one of most personal questions you can ask someone. Usually, veterans do not like answering this question because a) they have complicated feelings about it, and b) they do not know how you will respond to the answer, or whether you are ready to hear what they really have to say.

2. Are you crazy like the Vietnam vets?

*WHY NOT TO ASK:* Clearly there is a judgment attached to this question. There is no good way to answer it, so steer clear of asking it.

3. What do you think of the war (Abu Ghraib, atrocities, etc...)

*WHY NOT TO ASK:* This is a question whose answer may be very personal to a veteran. Moreover, the veteran may worry her answer may be one you don’t like or can’t relate to.

4. How did you get out of going?

*WHY NOT TO ASK:* This question implies that the veteran “tried” to get out of something, when it’s far more likely that he or she was not asked to deploy for one of many reasons related to their duty station or MOS.

5. How come you only did one tour?

*WHY NOT TO ASK:* The problem with this question lies in the word “only,” implying that serving one tour was not enough, or that the veteran may have shirked responsibility.

6. Good thing you didn’t see combat (to women).

*WHY NOT TO ASK:* In more than any previous war, female OIF & OEF veterans have been exposed to combat situations or have been in harm’s way. Even if someone has not been “in combat” per se, it is incorrect to suggest that their deployment was not stressful, dangerous or a major contribution.

7. At least you were only a... (cook, mechanic etc...)

*WHY NOT TO ASK:* Mostly because it’s insulting. In addition, the current conflicts are characterized by 360° of fighting. Serving “only” as a mechanic or cook, does not in any way guarantee your safety, particularly from IED’s and mortar or rocket attacks.

Developed by David M. Joseph, Ph.D with information adapted from presentations given by Minnesota Army National Guard Chaplain Lieutenant Colonel John Morris.
What is PTSD?

Posttraumatic stress disorder (PTSD) is an anxiety disorder that can occur after experiencing a traumatic event. During this type of event, you think that your life or others' lives are in danger. You may feel afraid or feel that you have no control over what is happening. If the symptoms last longer than 4 weeks, cause great distress, or interfere with work or home life, PTSD is one possible diagnosis.

What Are The Symptoms Of PTSD?

Symptoms of PTSD can be terrifying. They may disrupt your life and make it hard to continue with your daily activities. It may be hard just to get through the day.

1. Reliving the Event (re-experiencing symptoms):

   Bad memories of the traumatic event can come back at any time. When this happens, people may feel the same fear and horror they did when the event took place. Some of the most common ways that people relive traumatic events include:

   - **Intrusive Thoughts** – thinking about the event when you don’t want to.
   - **Nightmares** – some nightmares are not directly about the trauma, but are still reactions to it. It’s not unusual for veterans to wake up shaking or yelling after a particularly frightening or upsetting nightmare. It is also stressful for relationships.
   - **Flashbacks** – this is different from a typical memory. It can actually feel like you are there, and “it” is happening again.
   - **Triggers** – many things can trigger an emotional response or a re-experiencing of the trauma. Some triggers are obvious (helicopters and fireworks), while others are very subtle (feeling happy).

2. Avoiding Thoughts, Feeling, People And Places:

   Most people with PTSD try to avoid situations or people that trigger memories of the traumatic event. They may even avoid talking or thinking about the event. They may avoid engaging in things that elicit the same or similar feelings they experienced during a traumatic event. Common things to avoid include:

   - **Crowds in general (movies, sporting events, classrooms)**
   - **Tight spaces**
   - **Public Transportation**
   - **Feeling pressured or coerced**
3. Feeling Keyed Up Or Overwhelmed *(also called hyperarousal)*

Many people with PTSD report feeling jittery, or always alert and on the lookout for danger. This can lead to:

- *Feeling or acting suddenly (VERY) angry or irritable*
- *Sleep problems.*
- *Impaired concentration.*
- *Always feeling on guard.*
- *Easily startled*

4. Feeling Numb:

PTSD has been characterized as a disorder when one either feels too much (hyper-arousal) or too little (numb). While many people with PTSD feel it is their hyperarousal that is the most distressing to them, research suggests that it’s the numbing, avoiding and isolating that cause the most impairment in their social and occupational lives. Some examples of numbing include:

- Finding it hard to express feelings. This may be another way to avoid painful or uncomfortable memories.
- Finding it hard to have positive or loving feelings toward other people. Some may stay away from relationships, or isolate themselves from others.
- As with Depression, some find they are no longer interested or no longer get pleasure in activities they used to enjoy.

**What Are Other Common Problems?**

People with PTSD may also have other problems. These include:

- Drinking or drug problems.
- Feelings of hopelessness, shame, or despair.
- Employment problems.
- Relationships problems including divorce and violence.
- Physical symptoms.

**Are Treatments Effective?**

There are treatments available for PTSD that have shown great success in many cases. These therapies include Prolonged Exposure Treatment, Cognitive Processing Therapy, and EMDR.
Traumatic Brain Injury

Traumatic brain injury (TBI) occurs from a sudden blow or jolt to the head. A TBI is basically the same thing as a concussion. A TBI can be mild, moderate, or severe.

A TBI can occur even when there is no direct contact to the head. For example, when a person suffers whiplash, the brain may be shaken within the skull. This damage can cause bleeding between the brain and skull. Bruises can form where the brain hits the skull. Like bruises on other parts of the body, for mild injuries these will heal with time.

Most people who have a mTBI will be back to normal by 3 months without any special treatment. Even patients with moderate or severe TBI can make remarkable recoveries.

What are the common symptoms following a TBI?

Symptoms that result from TBI are known as post-concussion syndrome (PCS). Few people will have all of the symptoms, but even one or two of the symptoms can be unpleasant.

**Physical**
- Headache
- Feeling Dizzy
- Being Tired
- Trouble Sleeping
- Vision Problems
- Bothered By Noise And Light

**Cognitive (Mental)**
- Memory Problems
- Trouble Staying Focused
- Poor Judgment & Impulsivity
- Being Slowed Down
- Trouble Putting Thoughts Into Words

**Emotional (Feelings)**
- Depression
- Anger Outbursts And Quick To Anger
- Anxiety (Fear, Worry, Or Feeling Nervous)
- Personality Changes

Many of these symptoms will have a direct impact on a student’s academic performance.

Is it Possible to Have BOTH TBI & PTSD?

Many of the symptoms that follow a TBI overlap. Because TBI is caused by trauma and there is symptom overlap, it can be hard to tell what the underlying problem is. In addition, many people who get a TBI also develop PTSD. For this reason, it is very important to be assessed by a professional.

Suggested Readings, DVD’s and Websites

Books about the War, Trauma, and PTSD

Clinical or Therapeutic:


Reporting on the War:

1. **The Good Soldier.** By David Finkel

2. **War.** By Sebastian Junger

3. **Fiasco: The American Military Adventure in Iraq.** By Thomas E. Ricks

Personal Narratives:

1. **Ghosts of War: The True Story of a 19-Year-Old GI.** By Ryan Smithson

2. **Joker One: A Marine Platoon's Story of Courage, Leadership, and Brotherhood.** By Donovan Campbell

3. **The Unforgiving Minute: A Soldier's Education.** By Craig M. Mullaney

4. **Kaboom: Embracing the Suck in a Savage Little War.** By Matt Gallagher

Suggested Websites

**The National Center for PTSD:** [www.ptsd.va.gov](http://www.ptsd.va.gov)

A comprehensive website that includes both useful and current information for today’s veteran’s and their families, but also for clinicians and researchers. A complete database of research articles is available on their Pilot’s Database.

**www.afterdeployment.org:** An online resource supporting service member, veterans and their families with common post-deployment concerns. The website provides self-care solutions targeting posttraumatic stress, depression, anger, sleep, relationship concerns, and other mental health challenges.
**DVD’s about the Current Conflict**

1. **RESTEPRO:**
   "This is hard, hard duty. A 15-month tour. Our admiration for these men grows. Their jobs seem beyond conceiving. I cannot imagine a civilian thinking he could perform them.”
   – Roger Ebert, Chicago Sun-Times

2. **LIONESS:**
   “Powerful and provocative, LIONESS traces the stories of five female support soldiers who served in Iraq in various capacities mechanic, supply clerk, engineer and ultimately became the first women in American history to be sent into direct ground combat.”
   (Review from Amazon.com)

   “Combat Diary makes no political statements; conservatives and liberals can read their own messages into the movie’s stark, simple remembrances. But every American should watch Combat Diary and see, in the eyes of these men, what happens on the ground when a nation decides to go to war.” (Review from Amazon.com)

4. **ALIVE DAY MEMORIES: HOME FROM IRAQ**
   “Both tragic and profoundly uplifting, Alive Day Memories: Home From Iraq is a series of interviews with ten Iraq war veterans who have lost limbs, been blinded, been brain-damaged, or suffer from post-traumatic stress disorder. This documentary is only an hour long, but in that hour it unveils a range of emotion that a four-hour fictional movie could only begin to explore. The interviews, conducted by James Gandolfini (The Sopranos), capture these soldiers’ resolve, their humor, their regrets, their passion for life, and much, much more” (Review from Amazon.com)

5. **THE GROUND TRUTH**
   “Shocking and heartbreaking, The Ground Truth is an Iraq war documentary that is truly essential viewing. A story of the U.S. battle against an often-phantom insurgency, told from the perspective of ordinary Americans who found themselves participating in a daily slaughter of innocent Iraqi civilians, The Ground Truth is the view kept off American televisions since 2003.” (Review from Amazon.com)

6. **FRONTLINE: The Wounded Platoon**
   “ Tells the dark tale of the men of Third Platoon, Charlie Company, 1st battalion of the 506th infantry; and how the war followed them home. It is a story of heroism, grief, vicious combat, depression, drugs, alcohol and brutal murder; an investigation into the Army’s mental health services; and a powerful portrait of what multiple tours and post-traumatic stress are doing to a generation of young American soldiers.” (Review from Amazon.com)
Suicide: Precipitating Events

Personal security:
• Loss of job, home, money, status, self-esteem,
• Recent loss (especially a marriage or relationship)
• Being faced with humiliation or failure.
• Recent, loss (especially a marriage or relationship)
• Loss of health (real or imaginary).

Difficult times: holidays, anniversaries.
Suicide: Possible Warning Signs

- Appearing sad or depressed most of the time.
- Expressing feelings of excessive guilt or shame.
- Frequent and dramatic mood changes.
- Poor attendance when usually consistent.
- Neglecting personal welfare; deteriorating appearance.
- Anxious, agitated, unable to sleep, or sleeping all the time.
- Expressing feelings of excessive guilt or shame.
- Failure or decreased performance.
Timeline of a War: Afghanistan

“Operation Enduring Freedom”
(OLEF)
September 11, 2001

Terrorists Strike the United States

Al-Qaeda operatives hijack four commercial airliners, crashing them into the World Trade Center in New York and the Pentagon in Washington, DC. A fourth plane crashes in a field in Shanksville, Pennsylvania. Close to three thousand people die in the attacks. Although Afghanistan is the base for al-Qaeda, none of the nineteen hijackers are Afghan nationals. Mohammed Atta, an Egyptian, led the group, and fifteen of the hijackers originated from Saudi Arabia. President George W. Bush vows to “win the war against terrorism,” and later zeros in on al-Qaeda and Osama bin Laden in Afghanistan. Bush eventually calls on the Taliban regime to “deliver to the United States authorities all the leaders of al-Qaeda who hide in your land, for share in their fate.”

September 18, 2001

A War Footing

President George W. Bush signs into law a joint resolution authorizing the use of force against those responsible for attacking the United States on 9/11. This joint resolution will later be cited by the Bush administration as legal rationale for its decision to take sweeping measures to combat terrorism, from invading Afghanistan, to eavesdropping on U.S. citizens without a court order, to standing up the detention camp at Guantanamo Bay, Cuba.

October 07, 2001

The Opening Salvo

The U.S. military, with British support, begins a bombing campaign against Taliban forces, officially launching Operation Enduring Freedom. Canada, Australia, Germany, and France pledge future support. The war’s early phase (POW) mainly involves U.S. air strikes on al-Qaeda and Taliban forces that are assisted by a partnership of about one thousand U.S. special forces, the Northern Alliance, and ethnic Pashtun anti-Taliban forces. The first wave of conventional ground forces arrives twelve days later. Most of the ground combat is between the Taliban and its Afghan opponents.
March 2002

Mixed Signals

Operation Anaconda, the first major ground assault and the largest operation since Task Force Daka, is launched against an estimated eight hundred al-Qaeda and Taliban fighters in the Shah-i-Kot Valley south of the city of Gardez (Paktia Province). Nearly two thousand U.S. and one thousand Afghan troops battle the militants. Despite the operation's size, however, Anaconda does not represent a broadening of the war effort. Instead, Pentagon planners begin shifting military and intelligence resources away from Afghanistan in the direction of Saddam Hussein's Iraq, which is increasingly mentioned as a chief U.S. threat in the "war on terror."

May 01, 2003

'Major Combat' Over

During a briefing with reporters in Kabul, Secretary of Defense Donald Rumsfeld declares an end to "major combat." The announcement coincides with President George W. Bush's "mission accomplished" declaration of an end to fighting in Iraq. Rumsfeld says President Bush, U.S. Central Command Chief Gen. Tommy Franks, and Afghan President Hamid Karzai "have concluded that we are at a point where we clearly have moved from major combat activity to a period of stability and stabilization and reconstruction and activities." There are only eight thousand U.S. soldiers stationed in Afghanistan. It is predicted that the transition from combat to reconstruction will open the door for many aid organizations, particularly European groups, that had balked at sending troops, supplies, or other assistance.

July 2009

New Strategy, Old Battles

U.S. Marines launch a major offensive in southern Afghanistan, representing a major test for the U.S. military's new counterinsurgency strategy. The offensive, involving four thousand Marines, is launched in response to a growing Taliban insurgency in the country's southern provinces, especially Helmand Province. The operation focuses on restoring government services, bolstering local police forces, and protecting civilians from Taliban incursion. By August 2009 U.S. forces are to number between sixty thousand and sixty-eight thousand.
U.S. WAR IN AFGHANISTAN

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http://www.cfr.org/afghanistan/us-war-afghanistan/p20018
Timeline of a War: *Iraq*

“Operation Iraqi Freedom”

&

“Operation New Dawn”

(OIF) & (OND)
March 20, 2003

**War Begins**

President Bush announces U.S. forces have begun a military operation into Iraq. "These are opening stages of what will be a broad and concerted campaign," the president says. That initial effort to "decapitate" Iraq's leadership with air strikes fails, clearing the way for a ground invasion.

April 09, 2003

**A Regime Crumbles**

U.S., British, and other coalition forces quickly overwhelm the Iraqi Army, though elements loyal to Saddam Hussein who will form the core of a postwar insurgency fight on. Three weeks after the invasion, Iraqi civilians and U.S. soldiers pull down a statue of Saddam in Baghdad's Firdos Square.

May 01, 2003

**Mission Accomplished**

President Bush declares the end of major combat operations in Iraq from the deck of the aircraft carrier USS Abraham Lincoln. Lawlessness and some skirmishing in the country are written off as the desperate acts of "dead-enders" by Defense Secretary Donald Rumsfeld.
January 24, 2004

WMD Search Aborted

The Bush administration contends its prewar arguments about extensive stockpiles of chemical, biological, and even nuclear weaponry in Saddam Hussein's Iraq appear to have been mistaken. In January 2004, David Kay, the former top U.S. weapons inspector, tells Congress: "We were almost all wrong." A presidential commission concludes in March 2005 "not one bit" of prewar intelligence on Iraqi weapons of mass destruction panned out.

September 8, 2004

Battle for Fallujah

With Iraq's national elections approaching, fifteen thousand U.S. and Iraqi forces assault the insurgent stronghold of Fallujah in central Iraq. The urban fighting is successful but costly. Thirty-eight U.S. troops die, along with six Iraqi soldiers. The Pentagon estimates 1,200 insurgents are killed, and the Red Cross says eight hundred Iraqi civilians die with them.

October 15, 2005

Signs of Democracy

Despite violent outbreaks, 2005 is an election year for Iraq, and a sign of hope for Washington. In the fall, Shiites flash victory signs—ink-stained fingers—in front of an image of Shiite cleric Grand Ayatollah Ali al-Sistani after voting in Iraq's constitutional referendum. Two months later Iraqis vote for their first, full-term government, giving Shiites majority control of parliament.
January 10, 2007

The Surge

President Bush announces a “new way forward” in Iraq, vowing to commit an additional twenty thousand troops to bring stability in and around Baghdad. The Pentagon steps up its recruiting efforts in response, including the signing of newly naturalized soldiers like those, pictured here, who joined the fight during a ceremony at Camp Victory in July 2007.

September 14, 2007

Targeting U.S. Allies

With U.S.-assisted “Awakening Councils” making headway, insurgents target Sunnis now working with the United States. Ten days after meeting with President Bush in Anbar Province, Sheik Abdul Sattar Abu Risha, the most prominent figure in the revolt, is killed in an explosion near his home.

December 30, 2007

The Human Costs

U.S. war casualties total nine hundred in 2007, making the year of the “surge” the deadliest yet for U.S. soldiers. As the five-year anniversary approaches, nearly four thousand U.S. troops have died in the fighting, and an additional thirty thousand have been wounded. Here a woman in Santa Monica, California, pays homage to the dead at a war memorial.
February 01, 2009

The Drawdown Begins

Making good on a campaign pledge, President Obama announces plans to remove combat brigades from Iraq by August 2010. His plan will leave a transitional force of 35,000 to 50,000 soldiers and marines to train, advise, and advise Iraqi security forces until the end of 2011. Seen by many as the beginning of the end of the war, some experts express concern over the pacing, and Secretary of Defense Robert Gates says Washington should be prepared to maintain a “modest-sized presence” after the 2011 deadline if the Iraqis request it.

December 18, 2011

Final U.S. Troops Leave

The last U.S. soldiers leave Iraq, ending a nearly nine-year military mission. Since 2003, more than one million airmen, soldiers, sailors, and Marines served in the country. The costs of the conflict were high: $600 billion from the U.S. Treasury, with nearly 4,500 Americans and well over 100,000 Iraqis killed. U.S. troops brought the mission to an official close two days prior with a ceremony in Baghdad. Military forces will be succeeded by a diplomatic mission charged with overseeing U.S. interests in a country still struggling with security problems and deep-seated sectarian divisions.

http://www.cfr.org/iraq/timeline-iraq-war/p18876
October 5, 2011

The Military-Civilian Gap

War and Sacrifice in the Post-9/11 Era

FOR FURTHER INFORMATION, CONTACT
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Washington, D.C. 20036
www.pewsocialtrends.org
EXECUTIVE SUMMARY

The report is based on two surveys conducted by the Pew Research Center: one of the nation’s military veterans and one of the general public. A total of 1,853 veterans were surveyed, including 712 who served in the military after the attacks of Sept. 11, 2001. The general public survey was conducted among 2,003 adult respondents. (For a detailed description of the survey methodologies, see Appendix 1.)

Here is a summary of key findings:

The Rewards and Burdens of Military Service

- Veterans who served on active duty in the post-9/11 era are proud of their service (96%), and most (74%) say their military experience has helped them get ahead in life. The vast majority say their time in the military has helped them mature (93%), taught them how to work with others (90%) and helped to build self-confidence (90%). More than eight-in-ten (82%) say they would advise a young person close to them to join the military.

- At the same time, however, 44% of post-9/11 veterans say their readjustment to civilian life was difficult. By contrast, just 25% of veterans who served in earlier eras say the same. About half (48%) of all post-9/11 veterans say they have experienced strains in family relations since leaving the military, and 47% say they have had frequent outbursts of anger. One-third (32%) say there have been times where they felt they didn’t care about anything.

- Nearly four-in-ten (37%) post-9/11 veterans say that, whether or not they were formally diagnosed, they believe they have suffered from post-traumatic stress (PTS). Among veterans who served prior to 9/11, just 16% say the same.

- These psychological and emotional problems are most prevalent among post-9/11 veterans who were in combat. About half of this group (49%) say they have suffered from PTS. And about half (52%) also say they had emotionally traumatic or distressing experiences while in the military. Of those who had these types of experiences, three-in-four say they are still reliving them in the form of flashbacks or nightmares.
• Overall, about one-in-six post-9/11 veterans (16%) report they were seriously injured while serving in the military, and most of these injuries were combat-related. And about half (47%) say they know and served with someone who was killed while in the military, not significantly different from the share of pre-9/11 veterans (43%) who say the same. The survey finds that post-9/11 veterans who either experienced or were exposed to casualties are more supportive than other post-9/11 veterans of the wars in Iraq and Afghanistan. However, they also report having more difficulty re-entering civilian life.

The Military-Civilian Gap

• Only about one half of one percent of the U.S. population has been on active military duty at any given time during the past decade of sustained warfare. Some 84% of post-9/11 veterans say the public does not understand the problems faced by those in the military or their families. The public agrees, though by a less lopsided majority—71%.

• Some 83% of all adults say that military personnel and their families have had to make a lot of sacrifices since the Sept. 11, 2001, attacks; 43% say the same about the American people. However, even among those who acknowledge this gap in burden-sharing, only 26% describe it as unfair. Seven-in-ten (70%) consider it “just part of being in the military.”

• The public makes a sharp distinction in its view of military service members and the wars they have been fighting. More than nine-in-ten express pride in the troops and three-quarters say they thanked someone in the military. But a 45% plurality say neither of the post-9/11 wars has been worth the cost and only a quarter say they are following news of the wars closely. And half of the public say the wars have made little difference in their lives.

• At a time when the public’s confidence in most key national institutions has sagged, confidence in the military is at or near its highest level in many decades. However, just 58% believe the military operates efficiently. Among veterans of all eras, 66% say the military runs efficiently.

Post-9/11 Veterans and Their Wars

• Veterans are more supportive than the general public of U.S. military efforts in Afghanistan and Iraq. Even so, they are ambivalent. Just half of all post-9/11 veterans say that, given the costs and benefits to the U.S., the war in Afghanistan has been worth fighting. A smaller share (44%) says the war in Iraq has been worth it. Only one-third (34%) say both
Wars have been worth fighting, and a nearly identical share (33%) say neither has been worth the costs.

- About half of post-9/11 veterans (51%) say relying too much on military force creates hatred that leads to more terrorism, while four-in-ten endorse the opposite view: that overwhelming force is the best way to defeat terrorism. The views of the public are nearly identical: 52% say too much force leads to more terrorism, while 38% say using military force is the best approach.

- About six-in-ten post-9/11 veterans (59%) support the noncombat “nation-building” role the military has taken on in Iraq and Afghanistan. The public and pre-9/11 veterans are less enthused. Just 45% of both groups say they think this is an appropriate role for the military.

- While nation building gets mixed reviews, large majorities of veterans and the public support the use of unmanned “drone” aircraft for aerial attacks in Iraq, Afghanistan and elsewhere. Nearly nine-in-ten (86%) veterans of all eras say this is a good thing; 68% of the public agrees.

- Both the public and veterans oppose bringing back the military draft. More than eight-in-ten post-9/11 veterans and 74% of the public say the U.S. should not return to the draft at this time.

**A Profile of Post-9/11 Veterans**

- Politically, post-9/11 veterans are more likely than adults overall to identify with the Republican Party—36% are Republicans, compared with 23% of the general public. Equal shares of these veterans and the public call themselves independents (35%), while 21% of post-9/11 veterans and 34% of the public describe themselves as Democrats.

- In their religious affiliation, veterans are roughly comparable to the general population. Post-9/11 veterans are mostly young adults, and like younger Americans overall, they are more likely than the general public to say they have no particular religious affiliation (30% vs. 18%).

- Patriotic sentiment runs high among post-9/11 veterans. Six-in-ten (61%) consider themselves more patriotic than most other people in the country. Just 37% of Americans overall say the same.
• Post-9/11 veterans are happy with their lives overall, and they express high levels of satisfaction with their family life in particular. On these two measures they do not differ significantly from the public.

• When it comes to their financial well-being, post-9/11 veterans are somewhat less satisfied than the public overall—only 20% say they are very satisfied with their personal financial situation, compared with 25% of the public. Their dissatisfaction may be linked in part to high unemployment rates (11.5% of post-9/11 veterans were unemployed at the end of 2010).

A Profile of Today’s Active-duty Force

• The military in the post-9/11 era is older than the force that served a generation ago. While about two-thirds of active-duty military personnel are ages 30 or younger, the average age of enlisted personnel and officers has increased significantly since the draft ended in 1973.

• The percentage of minorities in the ranks of enlisted personnel and officers has increased significantly since 1990. In 2009, more than one-third of all active-duty personnel were minorities (36.2%), an increase from 25.4% about two decades ago. Women also comprise an increasing share of all active-duty officers and enlisted personnel.

• Today’s enlisted personnel are better educated than those who served before them. Fewer are high school dropouts and more are college graduates. In 2009, 92.5% of recruits were at least high school graduates, compared with 82.8% of comparably aged civilians.

• At a time when marriage rates are declining in the broader population, the share of active-duty military personnel who are married has increased dramatically in recent decades. Today, a majority of all enlisted personnel are married (53.1%), up from 40.1% in 1973. Overall, those in the military are significantly more likely to be married than are civilians of a comparable age.

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1 Figures for active-duty military personnel in this section are based on data published by the Department of Defense.
The Difficult Transition from Military to Civilian Life

By Rich Morin

Military service is difficult, demanding and dangerous. But returning to civilian life also poses challenges for the men and women who have served in the armed forces, according to a recent Pew Research Center survey of 1,853 veterans. While more than seven-in-ten veterans (72%) report they had an easy time readjusting to civilian life, 27% say re-entry was difficult for them—a proportion that swells to 44% among veterans who served in the ten years since the Sept. 11, 2001, terrorist attacks.

Why do some veterans have a hard time readjusting to civilian life while others make the transition with little or no difficulty? To answer that question, Pew researchers analyzed the attitudes, experiences and demographic characteristic of veterans to identify the factors that independently predict whether a service member will have an easy or difficult re-entry experience.

Using a statistical technique known as logistic regression, the analysis examined the impact on re-entry of 18 demographic and attitudinal variables. Four variables were found to significantly increase the likelihood that a veteran would have an easier time readjusting to civilian life and six factors predicted a more difficult re-entry experience.

Notes: For percentages based on full sample of veterans, n=1,842; for post-9/11 veterans, n=710. Unless otherwise noted, subsequent charts are based on all veterans.

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According to the study, veterans who were commissioned officers and those who had graduated from college are more likely to have an easy time readjusting to their post-military life than enlisted personnel and those who are high school graduates. Veterans who say they had a clear understanding of their missions while serving also experienced fewer difficulties transitioning into civilian life than those who did not fully understand their duties or assignments.

In contrast, veterans who say they had an emotionally traumatic experience while serving or had suffered a serious service-related injury were significantly more likely to report problems with re-entry, when other factors are held constant.

The lingering consequences of a psychological trauma are particularly striking: The probabilities of an easy re-entry drop from 82% for those who did not experience a traumatic event to 56% for those who did, a 26 percentage point decline and the largest change—positive or negative—recorded in this study.

In addition, those who served in a combat zone and those who knew someone who was killed or injured also faced steeper odds of an easy re-entry. Veterans who served in the post-9/11 period also report more difficulties returning to civilian life than those who served in Vietnam or the Korean War/World War II era, or in periods between major conflicts.

Two other factors significantly shaped the re-entry experiences of post-9/11 veterans but appear to have had little impact on those who served in previous eras. Post-9/11 veterans who were married while they served had a significantly more difficult time readjusting than did married veterans of past eras or single people regardless of when they served.

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1 An advantage of logistic regression analysis is that it estimates the effect of each variable controlling for the impact of all other variables in the model. For example, service in combat significantly increases the chances of having a difficult time adjusting to life after the military irrespective of the effect of being injured, having a traumatic experience while serving or any of the other positive or negative factors included in the model. Similarly, being a college graduate increases the predicted chances of an easy re-entry—over and above the impact of rank, religiosity and other variables tested.

2 Most of the estimated effects reported in this study are based on the change in probability between a veteran with a given experience or demographic characteristic (a commissioned officer, served since Sept. 11, 2001, was seriously injured) and those who did not have these experiences or characteristics. For some variables, the reported estimates are based on contrasts between two different levels of that variable. For example, the estimated effect of education on re-entry is based on the contrast between those who are college graduates and those whose formal education ended with high school graduation. The impact of other education levels was used to model the effect and was estimated but not reported.
At the same time, higher levels of religious belief, as measured by frequent attendance at religious services, dramatically increases the odds that a post-9/11 veteran will have an easier time readjusting to civilian life. According to the analysis, a recent veteran who attends religious services at least once a week has a 67 percent chance of having an easy re-entry experience. Among post-9/11 veterans who never attend services, the probability drops to 43%.

Eight other variables tested in the model proved to be poor predictors of how easily a veteran made the transition from military to civilian life. They are race and ethnicity (separate variables tested the effect of being white, black, Hispanic or some other race); age at time of discharge; whether the veteran had children younger than 18 while serving; how long the veteran was in the military; and how many times the veteran had been deployed.

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**Predicting the Ease of Re-entry**

This analysis employs a statistical technique known as logistic regression to measure the effect of any given variable on the likelihood that a veteran had an easy or difficult time re-entering civilian life while controlling for the effects of all other variables.

To identify the factors that best predicted an easy re-entry, eighteen independent variables were included in the regression model. The variables were chosen based on their predictive power in previous research. The demographics were: veteran's age at discharge; how long the individual served; the veteran's education, race and ethnicity (tested as four separate variables: white, black, Hispanic or some other race); whether the veteran was married or had young children while in the service; highest rank attained; and era in which the veteran served. Other variables tested the impact of specific experiences on re-entry: whether the veteran had been seriously injured while serving; experienced a traumatic or emotionally distressing event; served in a combat or war zone; or served with someone who had been killed or injured. A question that asked veterans whether they understood most or all of the missions in which they participated also was included.

Of the 18 variables in the model, ten turn out to be significant predictors of a veteran’s re-entry experience. Four were positively associated with re-entry: being an officer; having a consistently clear understanding of the missions while in the service; being a college graduate; and, for post-9/11 veterans but not for those of other eras, attending religious services frequently. Six variables were associated with a diminished probability that a veteran had an easy re-entry. They were: having a traumatic experience; being seriously injured; serving in the post-9/11 era; serving in a combat zone; serving with someone who was killed or injured; and, for post-9/11 veterans but not for those of other eras, being married while in the service.

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3 A possible explanation of the absence of an effect on older veterans is that the religion question asked how often a respondent currently attends religious services. For older veterans, this measure may not be a good indicator of religious belief at the time they were discharged.

4 To estimate the impact of church attendance and marital status while serving on recent veterans, the model was rerun using only the sample of those who served after Sept. 11, 2001.
Factors that Make Readjustment Harder

Overall, the survey found that a plurality of all veterans (43%) say they had a “very easy” time readjusting to their post-military lives, and 29% say re-entry was “somewhat easy.” But an additional 21% say they had a “somewhat difficult” time, and 6% had major problems integrating back into civilian life.

Among the 18 variables tested, veterans who experienced emotional or physical trauma while serving are at the greatest risk of having difficulties readjusting to civilian life. According to the analysis, having an emotionally distressing experience reduces the chances that a veteran would have a relatively easy re-entry by 26 percentage points compared with a veteran who did not have an emotionally distressing experience. Similarly, suffering a serious injury while serving reduces the probability of an easy re-entry by 19 percentage points, from 77% to 58%.

Overall, the survey found that serious injuries and exposure to emotionally traumatic events are relatively common in the military. Nearly a third (32%) of all veterans say they had a military-related experience while serving that they found to be “emotionally traumatic or distressing”—a proportion that increases to 43% among those who served since the Sept. 11, 2001, terrorist attacks. About one-in-ten veterans (10%) suffered a serious injury; of those who served in the post-9/11 era, 16% suffered a serious injury, in part because service members with serious injuries are more likely to survive today than in previous wars, when those with serious injuries died.

The survey also pinpoints some of the specific problems faced by returning service members who suffered service-related emotional trauma or serious injury. More than half (56%) of all veterans who experienced a traumatic event say they have had flashbacks or repeated distressing memories of the experience, and nearly half (46%) say they have suffered from...
post-traumatic stress. Predictably, those who suffer from PTS were significantly less likely to say their re-entry was easy than those who did not (34% vs. 82%).

According to the model, serving in a combat zone reduces the chances that a veteran will have an easier time readjusting to civilian life (78% for those who did not serve in a combat zone to slightly more than 71% for those who did). Knowing someone who was killed or injured also lessens the probability that a veteran will have an easy re-entry by six percentage points (73% vs. 79%).

**Service Era and Re-entry**

Many veterans who served after Sept. 11, 2001, have experienced difficulties readjusting to civilian life. The model predicts that a veteran who served in the post-9/11 era is 15 percentage points less likely than veterans of other eras to have an easy time readjusting to life after the military (62% vs. 77%).

A word of caution about comparing re-entry experiences between service eras. Those in the post-9/11 era were interviewed relatively soon after they left the military, and their views could reflect the immediacy of their experience and could change over time. For earlier generations of veterans, their views could have changed from what their views were at a similar point in their post-military lives.

Also, the overall view of veterans of earlier eras could change as members of this generation die and the composition of the cohort becomes different. As a consequence, these results are best interpreted as the views and experiences of current living veterans from each era, and not necessarily the views each generation held in the years immediately after leaving the service.

**Marriage and Re-entry**

The analysis produced a surprise. Post-9/11 veterans who were married while they were in the service also had a more difficult time readjusting to life after the military. Overall, being married while serving reduces the chances of an easy re-entry from 63% to 48%.

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At first glance, this finding seems counterintuitive. Shouldn’t a spouse be a source of comfort and support for a discharged veteran? Other studies of the general population have shown that marriage is associated with a number of benefits, including better health and higher overall satisfaction with life.6

In fact, the answer to another survey question points to a likely explanation. Post-9/11 veterans who were married while in the service were asked what impact deployments had on their relationship with their spouse. Nearly half (48%) say the impact was negative, and this group is significantly more likely than other veterans to have had family problems after they were discharged (77% vs. 34%) and to say they had a difficult re-entry.

Among those married while they were in the service, about six-in-ten (61%) post-9/11 veterans who had experienced marital problems while deployed also had a difficult re-entry. In contrast, about four-in-ten veterans (39%) who reported that deployments had a positive or no impact on their marriage say they had problems re-entering civilian life—virtually identical to the proportion of then-single post-9/11 veterans (37%) who experienced difficulties re-entering civilian life.

Taken together, these findings underscore the strain that deployments put on a marriage before a married veteran is discharged and after the veteran leaves the service to rejoin his or her family.

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Factors that Improve the Chances of an Easy Re-entry

Three variables tested in the model—rank at the time of discharge, how well the mission was understood and education level—emerged as statistically significant predictors of an easy re-entry experience for all veterans. A fourth variable, religiosity as measured by service attendance, is a powerful predictor of an easier re-entry experience for post-9/11 veterans but not for those who served in earlier eras.

The model predicts that commissioned officers are 10 percentage points more likely than enlisted personnel to experience few if any difficulties readjusting to life at home (85% vs. 74%), when all other factors are held constant. Veterans who say they clearly understood their missions while serving also were more likely than those who did not to have an easier re-entry (77% vs. 67%).

College-educated veterans also are predicted to have a somewhat easier time readjusting to life after the military than those with only a high school diploma. According to the analysis, a veteran with a college degree is five percentage points more likely than a high school graduate to have an easy time with re-entry (78% vs. 73%).

Again, a word of caution is in order. Veterans in the survey were asked how many years of school they have attended. Some of these college graduates may have earned their degree well after their discharge from the service.

Religiosity and Re-entry

Among the larger factors influencing the re-entry experience of post-9/11 veterans is religious faith, as measured by how often a recent veteran attends religious services. Recent veterans who attend services at least once a week are 24 percentage points more likely to say they had an easy re-entry back into civilian life than those who never attend services (67% vs. 43%). This finding is consistent with other studies of the general population that suggest religious belief is

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7 These probabilities have been rounded. The actual percentage-point difference is slightly more than 10 percentage points.
8 This variable was included in the model in an attempt to see if veterans who clearly understood their assignments and missions in the military had an easier or harder time readjusting to civilian life than those who did not have a clear understanding. It is possible that the causal relationship may flow in the other direction; that is, having an easy or difficult re-entry may shape veterans’ judgments about their military experience, including their attitude toward the missions they served. Omitting this variable from the analysis produces no significant changes in the model.
correlated with a number of positive outcomes, including better physical and emotional health, and happier and more satisfying personal relationships.9

The impact of religious observance vanishes if the sample is based only on those who completed their service before Sept. 11, 2001. In fact, there is barely a one percentage point difference in the probability of an easy re-entry between older veterans who currently attend religious services and those who never do.

As noted earlier, one reason for the absence of an impact may be related to the question measuring current attendance at religious services. This measure of attendance may be a good proxy for the religious convictions of more recent veterans. But it may be a poor estimate of how religious older veterans were immediately after they were discharged from the service. Over the years the religious belief of these older veterans may have changed, obscuring the impact of religious conviction on their re-entry experience.

![Religiosity, Re-entry and the Post-9/11 Veteran](chart.png)

**Religiosity, Re-entry and the Post-9/11 Veteran**

*Chances that post-9/11 veterans had an easy re-entry experience by how often they attend religious services*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a week or more</td>
<td>67%</td>
</tr>
<tr>
<td>Once or twice a month</td>
<td>61%</td>
</tr>
<tr>
<td>A few times a year</td>
<td>55%</td>
</tr>
<tr>
<td>Seldom</td>
<td>49%</td>
</tr>
<tr>
<td>Never</td>
<td>43%</td>
</tr>
</tbody>
</table>

Notes: Probabilities based on logistical regression analysis. Based on post-9/11 veterans, n=710.

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Prevalence of Mental Health Problems and Functional Impairment Among Active Component and National Guard Soldiers 3 and 12 Months Following Combat in Iraq

Jeffrey L. Thomas, PhD; Joshua E. Wilk, PhD; Lyndon A. Riviere, PhD; Dennis McGurk, PhD; Carl A. Castro, PhD; Charles W. Hoge, MD

Context: A growing body of literature has demonstrated the association of combat in Iraq and Afghanistan with postdeployment mental health problems, particularly posttraumatic stress disorder (PTSD) and depression. However, studies have shown varying prevalence rates of these disorders based on different case definitions and have not assessed functional impairment, alcohol misuse, or aggressive behavior as comorbid factors occurring with PTSD and depression.

Objectives: To (1) examine the prevalence rates of depression and PTSD using several case definitions including functional impairment, (2) determine the comorbidity of alcohol misuse or aggressive behaviors with depression or PTSD, and (3) compare rates between Active Component and National Guard soldiers at the 3- and 12-month time points following their deployment to Iraq.

Design: Population-based, cross-sectional study.

Setting: United States Army posts and National Guard armories.

Participants: A total of 18,305 US Army soldiers from 4 Active Component and 2 National Guard infantry brigade combat teams.

Interventions: Between 2004 and 2007, anonymous mental health surveys were collected at 3 and 12 months following deployment.

Main Outcome Measures: Current PTSD, depression, functional impairment, alcohol misuse, and aggressive behavior.

Results: Prevalence rates for PTSD or depression with serious functional impairment ranged between 8.5% and 14.0%, with some impairment between 23.2% and 31.1%. Alcohol misuse or aggressive behavior comorbidity was present in approximately half of the cases. Rates remained stable for the Active Component soldiers but increased across all case definitions from the 3- to 12-month time point for National Guard soldiers.

Conclusions: The prevalence rates of PTSD and depression after returning from combat ranged from 9% to 31% depending on the level of functional impairment reported. The high comorbidity with alcohol misuse and aggression highlights the need for comprehensive postdeployment screening. Persistent or increased prevalence rates at 12 months compared with 3 months postdeployment illustrate the persistent effects of war zone service and provide important data to guide postdeployment care.

Arch Gen Psychiatry. 2010;67(6):614-623

Two longitudinal studies of veterans of Operational Iraqi Freedom (OIF) and Operational Enduring Freedom (OEF) have shown that the incidence of posttraumatic stress disorder (PTSD) is 2 to 3 times higher among those exposed to combat compared with those who did not report significant combat exposure. These studies add to growing cross-sectional evidence linking combat duty in Iraq and Afghanistan to the development of postdeployment health problems including PTSD, depression, anxiety, and symptoms attributed to mild traumatic brain injury. Despite the strong association between combat and mental health problems, prevalence rates between studies have varied widely, most likely owing to differences in levels of combat exposure and to the case definitions used. Studies that use structured clinical interviews are costly and difficult to conduct with working infantry units, and most large studies of OIF or OEF combat veterans have relied on standardized self-report symptom scales, particularly the PTSD Checklist (PCL), which can be scored in several ways. To our knowledge, functional impairment measures have not been incorporated into any case definitions. The lack of...
of consistent definitions and functional impairment measures has made it difficult to determine the true effects of combat service in Iraq and Afghanistan or accurately project mental health service needs.

This study examines the prevalence rates of depression and PTSD in a large group of infantry soldiers at the 3- and 12-month time points following their deployment using several different case definitions including a measure of functional impairment. The study also evaluates alcohol misuse and aggressive behaviors, 2 comorbid conditions commonly reported in veteran populations.9–11

In addition, this study provides a unique look at differences between Active Component and National Guard soldiers. While Active Component soldiers have a federal mission to provide full-time military support for the defense of the nation, National Guard soldiers are part of the Reserve Component and primarily have a state mission to provide support to the community as citizen soldiers. During wartime, however, National Guard units can be federally mobilized to active duty to participate in direct combat operations in the same role as Active Component infantry brigade combat teams (BCTs); they have played a central role in OIF and OEF. Although approximately one-third of service members deployed to OIF/OEF have come from Reserve Component units, there is little research on the effect of OIF/OEF deployment by component.4,12

METHODS

DATA SOURCE

Between 2004 and 2007, we collected 18 305 anonymous surveys from members of 4 Active Component and 2 National Guard BCTs at 3 and 12 months postdeployment. Of the 18 305 surveys received, 13 226 were from veterans of OIF and were used for analysis. Our study extends a previous cross-sectional study conducted 3 to 4 months postdeployment 1 by increasing the sample size and adding a second cross-sectional evaluation of the same units at 12 months postdeployment. The 3-month time point was chosen based on research that found that assessing mental health 3 to 4 months postdeployment is optimal.13 The follow-up 12-month period was selected because it is the latest time that would ensure maximal participation without interfering with preparations for subsequent deployment. It is important to note that these units are not intended to be representative of all deploying military personnel but rather typical combat maneuver units of similar structure and function that were known to be at high risk owing to their mission to conduct ground combat operations. The 13 226 surveys used for analysis were obtained from 4933 soldiers from 4 Active Component BCTs at 3 to 4 months postdeployment; 4024 soldiers from these BCTs at 12 months postdeployment; 2684 soldiers from 2 National Guard BCTs at 3 to 4 months postdeployment; and 1585 soldiers from the same National Guard BCTs at the 12-month time point.

RECRUITMENT AND REPRESENTATIVENESS

The data were collected under a protocol approved by the Walter Reed Army Institute of Research institutional review board using procedures previously described.3 Recruitment briefings were scheduled at the convenience of the units, close to their work location. From the 6 participating BCTs, a combined total of approximately 29 460 soldiers were determined to be present in the units at the 2 time points based on information provided by unit personnel staff. Thus, the overall response rate was 62% (18 305 of 29 460 soldiers). This number is consistent with other research that used large population-based surveys and similar procedures.5,7,14,15 Most nonparticipation was related to not attending the recruitment briefings. At each data collection, research personnel conferred with the unit leadership and medical personnel to ensure that there were no systematic reasons that soldiers were not available to attend the briefings on the scheduled days. Reasons for unavailability included other duty or training obligations, medical appointments, illness, or unscheduled or personal leave.

In addition to determining the overall response rate in the units, the participation (consent) rate was calculated for soldiers who attended the recruitment briefing. Completion of any part of the paper-and-pencil survey was considered a response. The participation rate was 97% overall, ranging from 94% to 99% for all 12 data collections. Missing data on the surveys ranged from 2% to 10%; there was an average 2% of values missing for the combat exposure items, 2% for the PTSD items, 5% for the depression items, 7% for the aggression items, and 10% for the alcohol items. Finally, to assess the representativeness of our sample, we compared the demographics of soldiers from our sample to the demographic characteristics of all Active Component and National Guard OIF veterans with a combat occupational specialty. Demographics of OIF veterans were compiled from Post-Deployment Health Assessments from Army personnel obtained after their return from Iraq using the Defense Medical Surveillance System database (Table 1).

SURVEY MEASURES

Demographics and Combat Exposure Levels

Demographic measures included component, age, sex, race/ethnic group, education level, rank, and marital status (Table 1). A combat events checklist measured whether each event had occurred at least once during deployment (Table 2).

Posttraumatic Stress Disorder

We examined 7 case definitions of PTSD defined in Table 3. Posttraumatic stress disorder was measured using the 17-item PCL,4 well-validated in civilian and military primary care and mental health settings.8,16,17 The PCL is usually scored by summing the answers to the 17 questions (range, 17–85); a stringent cutoff of 50 or higher has been most widely used in military populations. The 7 definitions ranged from broad (liberal) to strict (conservative), based on DSM-IV B, C, and D symptom criteria, a high symptom severity cutoff score (≥50), and/or endorsement of functional impairment.8,16,18

Depression

We examined 3 case definitions of depression defined in Table 3. Depression was measured with the 9-item Patient Health Questionnaire (PHQ-9), a well-validated clinical scale for depression based on the DSM-IV criteria that is widely used in primary care and specialty mental health settings.18–20

Functional Impairment

Functional impairment due to depression was measured using the single item from the PHQ-9 that asks, “If you checked off any of the problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with
### Table 1. Demographics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Active Component</th>
<th>National Guard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 mo (n=4933)</td>
<td>12 mo (n=4024)</td>
</tr>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>2740 (56)</td>
<td>1908 (48)</td>
</tr>
<tr>
<td>25-29</td>
<td>1188 (24)</td>
<td>1083 (27)</td>
</tr>
<tr>
<td>30-39</td>
<td>903 (18)</td>
<td>907 (23)</td>
</tr>
<tr>
<td>≥40</td>
<td>93 (2)</td>
<td>115 (3)</td>
</tr>
<tr>
<td>Sex</td>
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</tr>
<tr>
<td>Male</td>
<td>4801 (98)</td>
<td>3876 (97)</td>
</tr>
<tr>
<td>Female</td>
<td>114 (2)</td>
<td>136 (3)</td>
</tr>
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<td>Race/ethnic groupb</td>
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<td></td>
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<tr>
<td>White</td>
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<td>2338 (59)</td>
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</tr>
<tr>
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<td>431 (11)</td>
</tr>
<tr>
<td>Other</td>
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<td>280 (7)</td>
</tr>
<tr>
<td>Educationc</td>
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<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>4360 (90)</td>
<td>3643 (92)</td>
</tr>
<tr>
<td>College graduate</td>
<td>501 (10)</td>
<td>318 (8)</td>
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<td>Military rankd</td>
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<tr>
<td>Junior enlisted</td>
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<td>2050 (52)</td>
</tr>
<tr>
<td>Junior noncommissioned</td>
<td>1381 (28)</td>
<td>1505 (38)</td>
</tr>
<tr>
<td>Senior noncommissioned</td>
<td>214 (4)</td>
<td>222 (6)</td>
</tr>
<tr>
<td>Officer</td>
<td>355 (7)</td>
<td>203 (5)</td>
</tr>
<tr>
<td>Marital status</td>
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<td></td>
</tr>
<tr>
<td>Single</td>
<td>2208 (51)</td>
<td>1395 (41)</td>
</tr>
<tr>
<td>Married</td>
<td>2148 (49)</td>
<td>1993 (59)</td>
</tr>
</tbody>
</table>

*Population reference group: army veterans of Operation Iraqi Freedom in combat occupation who responded to the Post-Deployment Health Assessment (PDHA), a medical screening conducted immediately postdeployment of returned soldiers. Post-Deployment Health Assessment data were collected from April 2, 2003, to June 18, 2008, and retrieved June 30, 2008.*

*b Items not asked on a 3-month survey of a National Guard unit.

c Items not asked on 3- and 12-month surveys of a National Guard unit.

*d Military ranks: junior enlisted are considered the ranks E1 to E4 (Private to Specialist); junior noncommissioned, E5 and E6 (Sergeant and Staff Sergeant); senior noncommissioned, E7 to E9 (Sergeant First Class to Sergeant Major); and officers, O1 and above. In a Brigade Combat Team, officers’ ranks range from O1 to O6, Second Lieutenant to 1 Colonel (the Commander).*

### Table 2. Combat Experiences

<table>
<thead>
<tr>
<th>Combat Experiences</th>
<th>Persons Who Experienced Event at Least Once During Deployment by Time After Deployment, No./Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>выборка укачивается</td>
<td>3 mo (n=4933)</td>
</tr>
<tr>
<td>Being attacked or ambushed</td>
<td>4437/4894 (91)</td>
</tr>
<tr>
<td>Receiving incoming artillery, rocket, or mortar fire</td>
<td>4529/4865 (93)</td>
</tr>
<tr>
<td>Receiving small arms fire</td>
<td>4354/4848 (89)</td>
</tr>
<tr>
<td>Shooting or directing fire at the enemy</td>
<td>3406/4872 (70)</td>
</tr>
<tr>
<td>Being responsible for the death of an enemy combatant</td>
<td>1830/4822 (38)</td>
</tr>
<tr>
<td>Being responsible for the death of a noncombatant</td>
<td>501/4845 (10)</td>
</tr>
<tr>
<td>Seeing dead bodies or human remains</td>
<td>4107/4565 (84)</td>
</tr>
<tr>
<td>Handling or uncovering human remains</td>
<td>2124/4851 (44)</td>
</tr>
<tr>
<td>Seeing dead or seriously injured Americans</td>
<td>3518/4888 (72)</td>
</tr>
<tr>
<td>Knowing someone seriously injured or killed</td>
<td>4244/4875 (87)</td>
</tr>
<tr>
<td>Seeing ill or injured women or children whom you were unable to help</td>
<td>3023/4865 (62)</td>
</tr>
<tr>
<td>Being wounded or injured</td>
<td>782/4861 (18)</td>
</tr>
<tr>
<td>Had a close call, was shot or hit, but protective gear saved you</td>
<td>600/4881 (12)</td>
</tr>
<tr>
<td>Had a buddy shot or hit who was near you</td>
<td>1270/4871 (26)</td>
</tr>
<tr>
<td>Clearing or searching homes or buildings</td>
<td>3722/4884 (76)</td>
</tr>
<tr>
<td>Engaging in hand-to-hand combat</td>
<td>963/4868 (20)</td>
</tr>
<tr>
<td>Saved the life of soldier or civilian</td>
<td>931/4802 (19)</td>
</tr>
</tbody>
</table>
other people?" This question has been shown to have acceptable correlations with standard measures of functional impairment and to be predictive of those with a depression diagnosis. To vary specificity and remain consistent with other studies in civilian and military populations, responses of "somewhat difficult" were considered to indicate some impairment and responses of "very difficult" or "extremely difficult" were considered to indicate serious impairment. Because the PCL lacks any measure of functional impairment and the single functional impairment question has been used with both the PHQ-9 and PHQ generalized anxiety scale, the same question was added below the 17 PCL questions.

### Alcohol Misuse

Soldiers were asked 2 yes/no screening questions about their alcohol use using a validated measure widely used in primary care; postdeployment screening, and in a predeploy-

<table>
<thead>
<tr>
<th>Measure</th>
<th>Specific Case Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td></td>
</tr>
<tr>
<td>PHQ, DSM-IV with no functional impairment</td>
<td>Respondent endorses at least 5 symptoms according to DSM-IV including &quot;feeling down, depressed or hopeless&quot; or &quot;having little interest in doing things&quot; for more than half of the days in the past month</td>
</tr>
<tr>
<td>PHQ, DSM-IV with some functional impairment</td>
<td>Respondent endorses at least 5 symptoms according to DSM-IV including &quot;feeling down, depressed or hopeless&quot; or &quot;having little interest in doing things for more than half the days in the past month&quot; and also expresses that these problems have made it at least somewhat difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PHQ, DSM-IV with serious functional impairment</td>
<td>Respondent endorses at least 5 symptoms according to DSM-IV including &quot;feeling down, depressed or hopeless&quot; or &quot;having little interest in doing things for more than half the days in the past month&quot; and expresses that these problems have made it very or extremely difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td><strong>PTSD</strong></td>
<td></td>
</tr>
<tr>
<td>PCL, DSM-IV</td>
<td>Respondent endorses the B, C, and D criteria: at least 1 reexperienced symptom (eg, nightmares), at least 3 avoidance or numbing symptoms (eg, avoiding things that remind them of the situation), and at least 2 symptoms of hyperarousal (eg, being easily startled) at the moderate or higher level</td>
</tr>
<tr>
<td>PCL, score ≥50</td>
<td>Respondent’s PCL score sums to ≥50</td>
</tr>
<tr>
<td>PCL, DSM-IV and score ≥50</td>
<td>Respondent endorses DSM-IV symptom cluster and scores ≥50 on PCL</td>
</tr>
<tr>
<td>PCL, DSM-IV with functional impairment</td>
<td>Respondent endorses DSM-IV symptom cluster and reports that symptoms of the disorder have made it at least somewhat difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PCL, DSM-IV with serious functional impairment</td>
<td>Respondent endorses DSM-IV symptom cluster and reports that symptoms of the disorder have made it very or extremely difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PCL, DSM-IV and score ≥50 with some functional impairment</td>
<td>Respondent endorses DSM-IV symptom cluster, scores ≥50 on PCL, and endorses that these problems have made it at least somewhat difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PCL, DSM-IV and score ≥50 with serious functional impairment</td>
<td>Respondent endorses DSM-IV symptom cluster, scores ≥50 on PCL, and endorses that these problems have made it very or extremely difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PHQ, DSM-IV or PCL, DSM-IV</td>
<td>Respondent endorses PHQ DSM-IV items or endorses PCL DSM-IV symptom cluster and reports that symptoms of the disorder have made it very or extremely difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PHQ, DSM-IV or PCL, DSM-IV and score ≥50</td>
<td>Respondent endorses PHQ DSM-IV items or endorses PCL DSM-IV symptom cluster plus a score of ≥50</td>
</tr>
<tr>
<td>PHQ, DSM-IV with some functional impairment; PCL, DSM-IV</td>
<td>(1) Respondent endorses PHQ DSM-IV items and reports that symptoms of the disorder have made it somewhat difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
<tr>
<td>PHQ, DSM-IV with serious functional impairment; or PCL, DSM-IV</td>
<td>(1) Respondent endorses PHQ DSM-IV items and reports that symptoms of the disorder have made it very or extremely difficult to do their work, take care of things at home, or get along with other people</td>
</tr>
</tbody>
</table>

Abbreviations: PCL, PTSD checklist; PHQ, Patient Health Questionnaire; PTSD, posttraumatic stress disorder.

* If respondent endorses self-harm for a few or several days, a positive screen is also indicated.
of the items 1 or more times in the past month was an indicator of aggressive behavior. When investigating the comorbidity of aggressive behavior with depression and PTSD, we used only the most specific item, “got into a fight with someone and hit the person,” as evidence of aggressive behavior. Although there are no published baseline comparisons, this item on lighting was used in the predeployment infantry sample included in Hoge and colleagues’ study 1; in that sample, 11.2% of soldiers endorsed this item.

QUALITY CONTROL PROCEDURES AND STATISTICAL ANALYSES

Surveys were optically scanned using the Scan Tools software package (Pearson Assessments Inc, Bloomington, Minnesota). Protocol quality control procedures stipulated that 10% of the surveys were randomly chosen and checked for scanning errors in all fields. The overall scanning error rate was 0.24% of all fields, a 99.76% accuracy rate.

The SPSS software (version 15.0; SPSS Inc, Chicago, Illinois) was used for analyses. Analyses included simple frequency and descriptive statistics, chi-square tests of association, and logistic regression analysis. Logistic regression was used to determine whether differences observed from the 3- and 12-month time points were significant in both the Active and National Guard groups while controlling for rank, marital status, and combat exposure, and to determine if changes in the prevalence rates from the 3- to 12-month time points differed between the Active Component and National Guard participants.

Table 1 displays the demographic characteristics for Active Component and National Guard soldiers at the 3- and 12-month time points following deployment. The demographic characteristics of personnel who took part in the study at the 3- and 12-month time points were similar to the reference population demographics of OIF combat veterans in both the Active Component and the National Guard. There were slight differences between the 3- and 12-month time points on rank, age, and marital status. Within a year of returning from deployment, it is common for soldiers to get promoted or married, so these were not unexpected. The demographic characteristics of the study groups were similar to those of the general reference population, except that officers were undersampled, resulting in lower rank and age distributions than in the reference groups. This is likely because officers were less available owing to work-related duties. Additionally, National Guard participants included a higher percentage of African American respondents than the reference group. This may be because the 2 National Guard BCTs are from states with a higher proportion of African American individuals than the reference group, which represented 50 states. Rates of combat exposure were similar to rates reported elsewhere. 2-4 Active Component and National Guard participants reported similar rates of exposure (Table 2).

Estimated PTSD prevalence based on DSM-IV symptom criteria ranged from 20.7% (Active Component, 3-month time point) to 30.5% (National Guard, 12-month time point). Most of these soldiers reported functional impairment at the “somewhat difficult” level, and a relatively high percentage reported serious impairment (“very difficult” or “extremely difficult” level). For example, PTSD rates based on DSM-IV criteria and serious functional impairment were 7.7% for the Active Component at 3 months and 8.9% at 12 months and 6.7% for the National Guard at 3 months and 12.4% at 12 months. More than 6% of the soldiers (and up to 11% of National Guard soldiers at 12 months) met the most stringent case criteria defined by the DSM-IV plus a high level of symptoms (PCL score, ≥50) and serious functional impairment.

For depression, estimated prevalence rates ranged from 11.5% (National Guard, 3-month time point) to 16.0% (Active Component, 3-month time point) using the PHQ definition alone. When using the PHQ definition plus serious functional impairment, rates were 8.3% and 8.5% for the Active Component (3- and 12-month time points) and 5.0% and 7.3%, respectively, for the National Guard. The estimated prevalence of either depression or PTSD based on the DSM-IV and using a high-specificity cutoff (PCL score, ≥50) ranged from 21.8% to 22.8% for Active Component (3 and 12 months) and 18.7% to 27.8% for National Guard soldiers, with most reporting some functional impairment. Prevalence rates for PTSD or depression with serious functional impairment ranged from 11.1% to 12.3% for Active Component and 8.5% to 14.0% for National Guard soldiers at 3 and 12 months, respectively.

COMPONENT DIFFERENCES FROM THE 3- TO 12-MONTH TIME POINT

Estimated prevalence rates of depression, PTSD, or the combination of PTSD or depression between the 3- and 12-month time points reveal a clear pattern across case definitions (Table 4).

(1) Symptoms of PTSD increased significantly in both groups but with much larger increases observed in National Guard participants. The Active Component group showed increased prevalence rates on 4 of the 7 PTSD diagnostic criteria: PTSD according to DSM-IV (broad); PTSD according to DSM-IV with some functional impairment; PTSD according to DSM-IV and a PCL score of 50 or higher with some functional impairment; and PTSD according to DSM-IV and a PCL score of 50 or higher with serious functional impairment. In the National Guard group there were significant increases from the 3- to the 12-month time point on all 7 case definitions of PTSD. (2) Estimated prevalence rates for depression symptoms increased significantly from the 3- to 12-month time points across all case definitions in the National Guard group only. (3) Estimated prevalence rates for PTSD or depression case definitions increased significantly from the 3- to 12-month time points for both the Active Component and National Guard groups on all 4 defined criteria. (4) The magnitude of the increase between 3 and 12 months was greater for the National Guard than for the Active Component group for several outcomes using logistic regression models that included a time-component interaction (Table 4). If the interac-
tation term was significant (P < .05), the magnitude of the change from 3 to 12 months for the National Guard group was significantly greater than the magnitude of the change for the Active Component group. In summary, depression and/or PTSD symptoms increased significantly in the National Guard from the 3- to 12-month time points across all case definitions, whereas in the Active Component, depression symptoms remained stable and PTSD symptoms increased across several criteria.

We also examined rates of alcohol misuse and aggressive behaviors (Table 5). We found a significant increase from the 3- to 12-month time point for National Guard soldiers in aggressive behaviors (ie, threatening someone with physical violence and getting into a fight and hitting the person). The prevalence rates of depression or PTSD with accompanying alcohol misuse or aggressive behavior were 9.7% and 14.7% for the 3- and 12-month time points, respectively, in the National Guard group. Using the most stringent criteria for a combination of depression or PTSD, serious functional impairment, and either alcohol misuse or aggressive behavior, the rates were 4.2% and 8.0%, respectively, for the 3- and 12-month time points in the National Guard group. The National Guard sample had higher prevalence rates across all combined criteria at the 12-month time point.

There were no significant changes from 3 to 12 months in the Active Component group for alcohol misuse or aggressive behaviors. A component effect was found; the magnitude of the increase on all comorbid criteria from 3 to 12 months was significantly different for the National Guard compared with Active Component soldiers.

### Table 5. Mental Health Problems

<table>
<thead>
<tr>
<th>Variable</th>
<th>Active Component</th>
<th>National Guard</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Postdeployment, No./Total (%)</td>
<td>Postdeployment, No./Total (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 mo (n=4933)</td>
<td>12 mo (n=4824)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Depression according to PHQ (no functional impairment)</td>
<td>757/4723 (16.0)</td>
<td>588/3749 (15.7)</td>
<td>1.04 (0.91-1.18)</td>
</tr>
<tr>
<td>Depression according to PHQ (some functional impairment)</td>
<td>694/4723 (14.7)</td>
<td>540/3749 (14.4)</td>
<td>1.06 (0.93-1.21)</td>
</tr>
<tr>
<td>Depression according to PHQ (serious functional impairment)</td>
<td>390/4723 (8.3)</td>
<td>320/3749 (8.5)</td>
<td>1.15 (0.97-1.36)</td>
</tr>
<tr>
<td>PTSD according to DSM-IV (broad definition)</td>
<td>1021/4933 (20.7)</td>
<td>954/4024 (23.7)</td>
<td>1.34 (1.20-1.51)</td>
</tr>
<tr>
<td>PTSD according to PCL high-specificity cutoff score (≥50)</td>
<td>778/4899 (15.9)</td>
<td>693/3963 (17.5)</td>
<td>1.22 (1.07-1.39)</td>
</tr>
<tr>
<td>PTSD according to DSM-IV and a high PCL cutoff score (≥50) (strict definition)</td>
<td>724/4899 (14.8)</td>
<td>656/3963 (16.6)</td>
<td>1.24 (1.08-1.41)</td>
</tr>
<tr>
<td>PTSD according to DSM-IV and a high PCL cutoff score (≥50) (some functional impairment)</td>
<td>994/4899 (20.3)</td>
<td>928/3963 (23.4)</td>
<td>1.31 (1.17-1.47)</td>
</tr>
<tr>
<td>PTSD according to DSM-IV and a high PCL cutoff score (≥50) (serious functional impairment)</td>
<td>377/4899 (7.7)</td>
<td>353/3963 (8.9)</td>
<td>1.25 (1.06-1.49)</td>
</tr>
<tr>
<td>PTSD according to DSM-IV and a high PCL cutoff score (≥50) (serious functional impairment)</td>
<td>619/4899 (12.6)</td>
<td>580/3963 (14.6)</td>
<td>1.28 (1.11-1.47)</td>
</tr>
<tr>
<td>PTSD according to DSM-IV and a high PCL cutoff score (≥50) (serious functional impairment)</td>
<td>310/4899 (6.3)</td>
<td>291/3963 (7.3)</td>
<td>1.24 (1.03-1.50)</td>
</tr>
</tbody>
</table>

**Abbreviations:** CI, confidence interval; OR, odds ratio; PCL, PTSD checklist; PHQ, Patient Health Questionnaire; PTSD, posttraumatic stress disorder.

a Time × component interaction using logistic regression, controlling for rank, marital status, combat exposure, and the time and component main effects.

b The 3- and 12-month differences remained significant at P < .05 after controlling for rank, marital status, and combat exposure using logistic regression.

c The time × component interaction was significant at P < .05.
The 3 objectives of the study, focused on delineating the broad mental health effects of combat deployment during the first year after return from Iraq, were to (1) examine the prevalence rates of depression and PTSD using several case definitions, with the addition of functional impairment, (2) examine the comorbidity of alcohol misuse or aggression behaviors with depression or PTSD, and (3) compare prevalence rates between Active Component and National Guard study groups.

Available data from deploying military samples indicate that the expected baseline (predeployment) rates of PTSD and depression are comparable with large population samples such as those found in the National Comorbidity Study. The baseline PTSD prevalence ranges from 3% to 5% (defined using the DSM definition combined with a PCL score ≥50); depression rates are also in the same range (3%-5%). It has been estimated that 9.3% of soldiers have either PTSD, depression, or generalized anxiety symptoms before deployment.

Using the least stringent definition, we observed PTSD rates across Active Component and National Guard study groups, study time points ranging from 20.7% to 30.5%, and depression rates ranging from 11.5% to 16.0%. Using the strictest definitions with high symptom rates and serious functional impairment, PTSD prevalence ranged from 5.6% to 11.3% and depression prevalence from 5.0% to 8.5%. Between 8.5% and 14.0% of all soldiers reported serious functional impairment due to either PTSD or depression symptoms.

### Table 5. Comorbidity of Alcohol Misuse or Aggression With Depression or PTSD

<table>
<thead>
<tr>
<th>Variable</th>
<th>Postdeployment, No./Total (%)</th>
<th>OR (95% CI)</th>
<th>P Value&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 mo (n=4933)</td>
<td>12 mo (n=4024)</td>
<td>3 mo (n=2684)</td>
</tr>
<tr>
<td>Alcohol misuse&lt;sup&gt;c&lt;/sup&gt;</td>
<td>575/4639 (12.4)</td>
<td>365/3698 (9.9)</td>
<td>0.90 (0.77-1.05)</td>
</tr>
<tr>
<td>Get angry with someone and kick, smash, or punch something</td>
<td>1981/4595 (43.1)</td>
<td>1451/3642 (39.8)</td>
<td>0.98 (0.90-1.08)</td>
</tr>
<tr>
<td>Threaten someone with physical violence</td>
<td>1719/4586 (37.5)</td>
<td>1285/3635 (35.4)</td>
<td>1.07 (0.97-1.19)</td>
</tr>
<tr>
<td>Get into a fight with someone and hit the person</td>
<td>813/4587 (17.7)</td>
<td>672/3647 (18.4)</td>
<td>1.28 (1.13-1.45)</td>
</tr>
</tbody>
</table>

### Abbreviations:
- CI, confidence interval; OR, odds ratio; PCL, PTSD checklist; PHQ, Patient Health Questionnaire; PTSD, posttraumatic stress disorder.
- a OR (95% CI) for 12 months compared with 3 months.
- b Time × component interaction using logistic regression, controlling for rank, marital status, combat exposure, and the time and component main effects.
- c Modified Two-Item Conjoint Screen for Alcohol Misuse (TICS).
- d The 3- and 12-month differences remained significant at P<.05 after controlling for rank, marital status, and combat exposure using logistic regression.
- e Depression according to PHQ or PTSD according to DSM-IV and fighting or TICS.
- f The time × component interaction was significant at P<.05.
- g Depression according to PHQ or PTSD according to DSM-IV and PCL high specificity cutoff score (≥50) and fighting or TICS.
- h Depression according to PHQ (some functional impairment) or PTSD according to DSM-IV and PCL high-specificity cutoff score (≥50; some functional impairment) and fighting or TICS.
- i Depression according to PHQ (serious functional impairment) or PTSD according to DSM-IV and PCL high-specificity cutoff score (≥50; serious functional impairment) and fighting or TICS.
This is the first study, to our knowledge, that looked at the prevalence in a population of veterans of OIF across different case definitions of PTSD with the addition of a functional impairment measure. The PTSD functional impairment question was modeled after the PHQ-9 measure for comparability and validity and showed that almost all soldiers who reported PTSD symptoms according to the DSM-IV also reported some functional impairment; roughly half reported serious impairment (at the “very difficult” or “extremely difficult” level).

The selection of both the DSM and the 50-point cutoffs as anchors for several of the PCL case definitions in this study is supported by a recent review of PCL studies that showed that a high cutoff is necessary to achieve the most accurate prevalence estimate in population research (as distinct from using the test in primary or specialty care settings).16 In this review, a cutoff of 48 to 50 produced the most accurate estimate of PTSD prevalence in a hypothetical population, with a true prevalence rate of PTSD of 15%. Lower cutoff values produced significant overestimates of prevalence because of the higher number of false positives and lower positive predictive value. Applying the DSM definition to the PCL has been shown to correspond to a somewhat lower PCL cutoff of 44 in a military sample.16 Our study expands on this knowledge by applying the different definitions with the addition of functional impairment.

These prevalence rates based on functional impairment are consistent with earlier estimates in OIF/OEF infantry populations based only on high symptom endorsement.3 For example, Hoge et al reported that 12.9% of infantry populations based only on high symptom endorsement are consistent with earlier estimates in OIF/OEF on this knowledge by applying the different definitions has been shown to correspond to a somewhat lower PCL predictive value. Applying the higher number of false positives and lower positive predictive value. Applying the DSM definition to the PCL has been shown to correspond to a somewhat lower PCL cutoff of 44 in a military sample.16 Our study expands on this knowledge by applying the different definitions with the addition of functional impairment.

These prevalence rates based on functional impairment are consistent with earlier estimates in OIF/OEF infantry populations based only on high symptom endorsement.3 For example, Hoge et al reported that 12.9% of Active Component soldiers met PTSD criteria 3 to 4 months postdeployment using a DSM definition combined with a PCL score of 50 or higher. In our study, in the Active Component sample at 3 months, 14.8% met the criteria for PTSD using the same criteria that Hoge used, 12.6% met criteria using the DSM plus high symptom severity (PCL score ≥50) and some functional impairment, and 6.3% met the most stringent definition, DSM plus high symptom severity (PCL score, ≥50) and serious functional impairment.

This study also showed that comorbid alcohol misuse or aggressive behavior was common across all case definitions. Around 50% of soldiers who screened positive for depression or PTSD, based on the strict definition, also met criteria for alcohol misuse or aggressive behavior (Table 5); aggressive behaviors showed increases in both Active Component and National Guard soldiers from the 3 and 12 months time points. The significant overlap between alcohol misuse, aggressive behavior, and mental disorders highlights the high rate of comorbidity in this population. Responses to the items that assessed aggressive behavior and alcohol misuse had slightly more missing data (7% and 10%, respectively) than other study measures, likely owing to the sensitive nature of endorsing alcohol misuse and aggressive behaviors in this occupational setting. However, we do not believe that the missing data for these items occurred at high enough rates to affect the results given the high valid response rate (more than 90%) and the consistency in the findings across different population subgroups and definitions. These findings indicate that it may be beneficial to screen for alcohol and aggressive behaviors when soldiers present for treatment of PTSD or depression.

Despite efforts to systematically assess soldiers following deployment, dispel stigma, encourage treatment, and improve access to care, the prevalence rates across the study’s case definitions showed increases from the 3- to 12-month time points. These data make clear that, at 12 months following deployment, many combat soldiers have not psychologically recovered, which has immediate implications for current Department of Defense policy and troop rotations supporting OIF and OEF. The time between deployments (dwell time) has been 12 to 18 months for many Active Component combat units. While these data do not directly assess whether increasing dwell time between deployments would be associated with lower mental health disorder rates in returning veterans, the data indicate that, for many, 12 months appears to be insufficient time to recover. Because PTSD may develop or persist months after exposure to trauma, interventions are thought to be best provided as early as possible after returning home.8 Providing the time for treatment, intervention, and psychological recovery following deployment is particularly important because many Active Component BCTs have deployed 3 or 4 times to Iraq or Afghanistan, and many National Guard BCTs have also deployed on more than 1 combat tour in the past 8 years, with each extending greater than 12 months with predeployment training.

Increases in the prevalence rates of mental health problems from the 3- to 12-month time points postdeployment were significantly greater among National Guard soldiers. National Guard and Active Component soldiers reported similar rates of combat experiences and similar prevalence rates of mental health problems 3 months postdeployment. Therefore, the emergence of differences by 12 months likely does not have to do with differences in the health effects of combat but rather with other variables related to readjustment to civilian life or access to health care (as noted previously by Department of Defense researchers6). Because National Guard soldiers return to civilian status following their deployment, they do not have the same uninterrupted access to military medical care as Active Component soldiers. National Guard soldiers have access to free military medical coverage until 6 months following their deployment, after which they may purchase additional coverage or receive care at veterans affairs medical facilities.26 However, these facilities are often not as conveniently located compared with medical facilities on the same posts as the Active Component units. Other potential differences between National Guard and Active Component soldiers include the time spent continuing to work with unit peers who may provide support for deployment-related problems and the stresses of reintegrating with civilian society and civilian employment. Another difference is that at 12 months postdeployment, Active Component soldiers are becoming collectively focused on the multiple tasks required to prepare a unit for another deployment including heavy training schedules (ie, field exercises). This high level of work engagement may result in less time to address personal problems or lingering mental health issues from a previous deployment.
LIMITATIONS

The data reported here were collected using a cross-sectional design similar to previous studies with large intact military units. Because the survey was anonymous, the data are not longitudinal. However, we are confident that the cross-sectional data were representative of soldiers in combat infantry units who returned from Iraq. Although some soldiers move to other duty locations or leave service shortly after returning home, most remain in the unit with which they deployed. The estimated turnover is 28% during the first year post-deployment (based on the surveys received from those who did not deploy), and it is likely that many soldiers in our study completed both surveys. The study groups also had comparable demographics with the Army combat occupational reference groups, and combat exposure levels were similar to those found in other studies.

There is potential selection bias in terms of soldiers who were available to take part in the survey. The participating units scheduled the recruitment and survey sessions to minimize adverse effects on the work requirements. However, some soldiers may not have been available owing to reasons such as temporary duty elsewhere, being on leave, or attending schools or training. Soldiers who were ill or injured, or who had been removed from the unit for administrative reasons such as drug abuse or misconduct, would also not have been available to take part in the survey. This potential bias is most likely to lead to underreporting of mental health problems in the study population compared with the larger population. Compensation-seeking bias is not likely, given that the surveys were anonymous and not linked in any way with health care or disability agency processes. Although officers typically have lower rates of mental health problems than enlisted soldiers, the undersampling of officers would have had a minimal effect on overall prevalence rates because officers account for less than 15% of all personnel in these combat units.

Additionally, although the sample only included 2 National Guard BCTs (compared with 4 Active Component BCTs), the findings of this study were consistent with another study indicating that soldiers from Reserve Component units appear to have greater increases in mental health problems after returning home than soldiers from active units. As a whole, our sample of National Guard soldiers was similar to the National Guard reference population on demographic variables other than race/ethnicity. Most importantly, National Guard soldiers were comparable with Active Component soldiers on combat exposure, a leading predictor of postdeployment mental health problems.

IMPLICATIONS AND FUTURE RESEARCH

From an epidemiological perspective, the present study is an important contribution to the literature because it provides a comprehensive assessment of how different case definitions influence PTSD and depression prevalence in combat veterans. Using the same case definition reported by Hoge and colleagues across study groups and time points, 23% to 31% of soldiers described symptoms that met DSM criteria for PTSD or depression along with some functional impairment. Using an even stricter case definition including reporting serious functional impairment across study groups and time points, 9% to 14% still met criteria. Further studies are needed to better understand the nature and severity of the impairment along multiple dimensions to include work, family, and social relationships. Research is also needed to better quantify the effect of comorbid factors such as alcohol misuse, aggression, risk-taking behaviors, and physical symptoms to understand the full extent of the effects of war-related trauma.

We believe that these data have clear implications for the care of soldiers and their families. The findings of the study show that at 12 months following combat, the prevalence of mental health problems among veterans does not abate, and in many cases, increases. It is a virtual certainty that soldiers who remain in service will deploy again; this study shows that a sizable proportion (9%-14%) have depression or PTSD symptoms with serious functional impairment. Data collected from the US Army's Mental Health Advisory Teams has clearly demonstrated that multiple deployments are associated with a higher prevalence of mental health problems, and the cumulative effects of combat deployments are worrisome. These data also have implications for individual soldiers and unit peers. If soldiers who are struggling with serious functional impairment as the result of a previous deployment are deployed again, there is potential that this could impair their performance in combat. This has implications for the safety of unit members and mission success. Further research is needed to understand the effects of self-perceived serious impairment and military occupational performance.

Our findings showed that National Guard soldiers' mental health problems increased dramatically from the 3- to 12-month time points. Therefore, it is imperative that members of the National Guard and other Reserve Component units have as ready access to care as Active Component members beyond the first few months of returning home. Functionally and culturally, National Guard soldiers are different from Active Component soldiers in that they return to civilian life after combat and have more restricted health care access. It will continue to take a collective effort from Department of Defense, Veterans Affairs, community providers, and veteran organizations to help this generation's veterans readjust after service in Iraq and Afghanistan.
chiatry, Walter Reed Army Institute of Research, 503 Robert Grant Ave, Silver Spring, MD 20910 (Jeffrey L. Thomas @us.army.mil).

Author Contributions: Dr Thomas had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Financial Disclosure: None reported.

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Disclaimer: The material has been reviewed by the Walter Reed Army Institute of Research. There is no objection to its presentation and/or publication. The opinions or assertions contained herein are the private views of the authors, and are not to be construed as official, or as reflecting true views of the Department of the Army or the Department of Defense.

Additional Contributions: We thank the leaders and the soldiers of the units studied for their service to our nation and their participation in the study. We thank Paul Bliese, PhD, and Richard Herrell, PhD, for their guidance on the manuscript. We thank the Walter Reed Army Institute of Research Land Combat Study Team who collected the data: Wanda Cook, Allison Whit, Tony Cox, MSW, Oscar Cabrera, PhD, Michael Wood, PhD, Dave Cotting, PhD, Tim Allison-Aipa, PsyD, Julie Clark, MA, Paul Kim, MA, Karen Eaton, MA, Matthew Baker, MA, Athena Kendall-Robbins, MA, Kyle Schaual, Megan Legenos, Nickolas Hamilton, Lloyd Shanklin, Nadia Kendall-Diaz, Duriel Randolph, Michael Brouillard, Lakisha Holley, and Akeiya Briscoe-Cureton.

REFERENCES


5. Hoge CW, Hoge JW, Miliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. 2006;295(9):1023-1032.


Select excerpts:

Invisible Wounds: Serving Service Members and Veterans with PTSD and TBI

National Council on Disability
March 4, 2009

This report is available on the National Council on Disability (NCD) Web site (www.ncd.gov).

Executive Summary
More than 1.6 million American service members have deployed to Iraq and Afghanistan in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). As of December 2008, more than 4,000 troops have been killed and over 30,000 have returned from a combat zone with visible wounds and a range of permanent disabilities. In addition, an estimated 25-40 percent have less visible wounds—psychological and neurological injuries associated with post traumatic stress disorder (PTSD) or traumatic brain injury (TBI), which have been dubbed “signature injuries” of the Iraq War. [Invisible Wounds, 2009:1]

Section 1: Introduction
American service members have sacrificed a great deal in the battles in Afghanistan and Iraq, and many of those who have returned are still battling. Only now they are not fighting the enemy around them. They are, at times, fighting an even more elusive foe within—the psychological effects of war. This foe is often not recognized or acknowledged. Moreover, the system that provides treatment for psychological trauma for veterans is not always well implemented.

More than 1.6 million American service members have deployed to Iraq and Afghanistan in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), and over 565,000 have deployed more than once (Veterans for Common Sense, 2008). As of December 2008, more than 4,200 troops have been killed and over 30,800 have returned from a combat zone with visible wounds and a range of permanent disabilities (O’Hanlon and Campbell 2008). In addition, an estimated 25-40 percent have less visible wounds—psychological and neurological injuries associated with Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI) (Tanielian and Jaycox 2008; Hoge, et al. 2008).

It is common to make a distinction between visible injuries such as orthopedic injuries, burns, and shrapnel wounds and less visible injuries such as PTSD. The distinction often is characterized as “physical” versus “mental” injuries. These terms imply that PTSD somehow is not physical. However, this is an artificial distinction. PTSD and other “mental illnesses” are characterized by measurable changes in...
the brain and in the hormonal and immune systems. In this report, we use the terms “visible” and “not visible” to make the distinction. [Invisible Wounds, 2009:8]

Section 6: Barriers to Seeking Care

I served in Baghdad from April 2003 to May 2004... September of 2003 I was sent for treatment ...I met with a Major there a couple of times who put me on three different antidepressants. For those of you who have been there, you know how difficult this is. For one, just the PTSD and Combat Stress Control is a huge stigma that generally isn't viewed too kindly by the chain of command. Add to this the fact that I was an NCO in charge of a combat engineer team who prided themselves in their “sapper” skills.

But the other difficult part is actually getting the antidepressants you were prescribed. For us, there wasn't a pharmacy anywhere nearby; you had to go to the Green Zone.

Lejeune, Chris. From his blog on The VetVoice Diaries.

Researchers have found that among the military service members who have returned from Iraq and Afghanistan and report symptoms of post traumatic stress disorder or major depression, only slight more than half have sought treatment (Tanielian and Jaycox 2008). Barriers to seeking care fall into two general categories: stigma and access (Hoge et al. 2004).

1. Stigma

Three unique types of stigma pose barriers to treatment (Sammons 2005):

Public Stigma refers to the public (mis)perceptions of individuals with mental illnesses. Over half of surveyed soldiers who met criteria for a psychological health problem thought they would be perceived as weak, treated differently, or blamed for their problem if they sought help (Hoge et al. 2004; US DoD Task Force on Mental Health 2007).

Self Stigma refers to the individual internalizing the public stigma and feeling weak, ashamed and embarrassed.

Structural Stigma refers to the institutional policies or practices that unnecessarily restrict opportunities because of psychological health. Service members repeatedly report believing that their military careers will suffer if they seek psychological services. They believe that seeking care will lower the confidence of others in their ability, threaten career advancement and security clearances, and possibly cause them to be removed from their unit (US DoD Task Force on Mental Health 2007).

The Army has made a concerted effort to reduce the stigma associated with psychological health issues and the efforts seem to have had a positive effect. Based on the Army’s annual survey of soldiers in theater, fewer soldiers who met the screening criteria for a mental disorder report that stigma affected
their decision to seek treatment in 2007 than in 2006. However, the levels remain unacceptably high as over half of male soldiers in Iraq who meet the screening criteria were concerned that they “would be seen as weak” and 40 percent believed that their leaders would blame them for the problem (US Army Surgeon General 2008) (Exhibit 4).

**Exhibit 4: Perceived Barriers to Seeking Mental Health Services, 2006 and 2007**

<table>
<thead>
<tr>
<th>Factors that Affect the Decision to Seek Mental Health Treatment</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be seen as weak</td>
<td>53</td>
<td>50</td>
</tr>
<tr>
<td>Members of my unit might have less confidence in me</td>
<td>51</td>
<td>45</td>
</tr>
<tr>
<td>My leaders would blame me for the problem</td>
<td>43</td>
<td>39</td>
</tr>
<tr>
<td>It would harm my career</td>
<td>34</td>
<td>29</td>
</tr>
<tr>
<td>It would be too embarrassing</td>
<td>37</td>
<td>34</td>
</tr>
</tbody>
</table>

Source: Data from MHAT-V 2008

2. **Access**

Even when service members or veterans decide to seek care, they need to find the “right” provider at the “right” time. As described in section 5, this is not always possible. When care is not readily available the “window of opportunity” may be lost.

In contrast to the data collected by DoD on barriers to mental health care, there is currently a dearth of information on barriers to care for OIF/OEF veterans seeking VA care. VA publishes patient satisfaction data, but by definition this data only reflects the views of veterans who have overcome whatever barriers that exist and succeeded in gaining access to care. A feedback loop which includes the systematic collection of data on the perception of consumers about the ease of access to care is crucial to identify and decrease barriers to care. No such mechanism for VA care currently exists.

A recurring survey of a national sample of OIF/OEF veterans, including those who do not currently utilize VA services could identify barriers to care, such as: distance from required specialized services; availability of specified types of service including early intervention services; bureaucratic obstacles to accessing care; user friendliness; clinic hours and policies; perceived stigma and concerns with impact on job or reserve unit status; and lack of information about what services are available.

3. **Additional Issues for Certain Populations**

A. **Culturally Diverse Populations**

Little attention has been paid to the unique needs of culturally diverse populations with PTSD. Despite
high rates of PTSD, African-American, Latino, Asian, and Native American veterans are less likely to use mental health services for several reasons:

**Cultural competency of providers:** A study of Native American and Latino veterans identified several barriers to VA services: 85 percent felt “VA care-givers know little about ethnic cultures,” and 79 percent felt that “VA care-givers have problems talking with ethnic veterans” (Nugent et al. 2000). Although little research on the issue specifically focuses on veterans, studies in the civilian sector suggest that individuals are more likely to follow through with therapy if the clinician and client are matched ethnically (Norris and Alegria 2005). The scarcity of minority providers makes this unlikely for most nonwhite veterans. In addition, many intervention materials are unknowingly embedded with cultural expectations and unsubstantiated assumptions about such issues as time orientation, social and occupational commitments, family structure, and gender roles.

**Stigma:** Compared to white veterans, African-American veterans are more likely to feel shame and guilt for their PTSD. Latinos are more likely to believe that asking for help will bring dishonor to their families. These responses are exacerbated because both groups are more likely to feel that a health provider has judged them unfairly (Norris and Alegria 2005).

**Linguistic access:** Although most service members and veterans are fluent in English, their family members may have limited English proficiency. Given the important role of families in encouraging veterans to seek services and in locating those services, multilingual outreach and family support is necessary. VA-wide publications such as “VA Benefits” are available in several languages. However, most material, including outreach material, is developed by local or regional VA entities (such as a Vet Center or a VISN), and those entities develop materials in languages other than English at their discretion. The VA Center for Minority Veterans encourages, but cannot require, that materials be available in other languages.

**B. Women**

Women make up about 10 percent of the US forces in Iraq and Afghanistan. Some of these women have been returning from Iraq not only with combat-related trauma, but also with Military Sexual Trauma (MST). Although estimates vary, between 13 percent and 30 percent of women veterans experienced rape, and a higher percentage experienced some type of sexual trauma over the course of their military careers. The sexual trauma combined with combat trauma makes women far more likely to experience PTSD (Yeager et al. 2006).

The military’s response to individual reports of MST, and the barriers that women face in reporting this trauma, is beyond the scope of this report. VA has established a number of programs to address the impact, including Military Sexual Trauma counseling, Women Veterans Stress Disorders Treatment Teams, and MST centers. [Invisible Wounds, 2009:51-54]
References


http://www.vetvoice.com/showDiary.do?diaryId=874


http://www.brookings.edu/saban/iraq-index.aspx


Hannah Fischer
Information Research Specialist

September 28, 2010
Summary

This report presents difficult-to-find statistics regarding U.S. military casualties in Operation New Dawn (OND), Operation Iraqi Freedom (OIF), and Operation Enduring Freedom (OEF, Afghanistan), including those concerning post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), amputations, evacuations, and the demographics of casualties. Some of these statistics are publicly available at the Department of Defense’s (DOD’s) website, while others have been obtained through contact with experts at DOD.


This report will be updated as needed.
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Operation New Dawn

On August 31, 2010, President Obama announced that the U.S. combat mission in Iraq had ended. A transitional force of U.S. troops will remain in Iraq with a different mission: “advising and assisting Iraq’s Security Forces, supporting Iraqi troops in targeted counterterrorism missions, and protecting our civilians.”

As of September 28, 2010, six servicemembers have died in Operation New Dawn (OND). Also, 16 servicemembers in OND have been wounded and not returned to duty and 14 servicemembers in OND have been wounded and returned to duty.

Rates of Post-Traumatic Stress Disorder, Traumatic Brain Injury, and Amputation

Post-Traumatic Stress Disorder

The U.S. Army Office of the Surgeon General provided the statistics below on the incidence of post-traumatic stress disorder (PTSD) cases. A case of PTSD is defined as an individual having at least two outpatient visits or one or more hospitalizations at which PTSD was diagnosed. The threshold of two or more outpatient visits is used to increase the likelihood that the individual actually had PTSD.

A single visit on record commonly reflects someone who was evaluated for possible PTSD, but did not actually meet the established criteria for diagnosis. In addition, although the diagnosis of PTSD occurred at some point after the individual deployed, there is no way to determine that the PTSD resulted from an event associated with the deployment, that is, it could have resulted from an event that occurred after return from or prior to a deployment.

The Army has 67% of the cases, the Air Force has 9%, the Navy has 11%, and the Marines have 13%. Table 1 and Figure 1 present yearly PTSD diagnoses for all services.

---


3 Personal communication with CRS from Department of Defense Office of the Secretary of Defense liaison, September 21, 2010.
Table 1. Annual New Post-Traumatic Stress Disorder Diagnoses in All Services
As of September 7, 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Not Deployed</th>
<th>Deployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>1,614</td>
<td>0</td>
</tr>
<tr>
<td>2001</td>
<td>1,703</td>
<td>0</td>
</tr>
<tr>
<td>2002</td>
<td>1,709</td>
<td>138</td>
</tr>
<tr>
<td>2003</td>
<td>1,524</td>
<td>1,169</td>
</tr>
<tr>
<td>2004</td>
<td>1,577</td>
<td>3,901</td>
</tr>
<tr>
<td>2005</td>
<td>1,648</td>
<td>6,788</td>
</tr>
<tr>
<td>2006</td>
<td>1,714</td>
<td>7,762</td>
</tr>
<tr>
<td>2007</td>
<td>2,069</td>
<td>11,660</td>
</tr>
<tr>
<td>2008</td>
<td>2,371</td>
<td>14,183</td>
</tr>
<tr>
<td>2009</td>
<td>2,432</td>
<td>13,595</td>
</tr>
<tr>
<td>2010</td>
<td>1,423</td>
<td>7,739</td>
</tr>
<tr>
<td>Total</td>
<td>21,784</td>
<td>66,935</td>
</tr>
</tbody>
</table>


Figure 1. Annual Post-Traumatic Stress Disorder Diagnoses in All Services
As of September 7, 2010

Traumatic Brain Injury

The Defense and Veterans Brain Injury Center gives the following incidence of traumatic brain injury (TBI):

Table 2. Traumatic Brain Injuries in the U.S. Military

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010 Q1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Diagnoses</td>
<td>10,963</td>
<td>11,830</td>
<td>12,469</td>
<td>12,886</td>
<td>13,271</td>
<td>12,025</td>
<td>16,873</td>
<td>23,002</td>
<td>28,557</td>
<td>27,862</td>
<td>7,604</td>
<td>178,876</td>
</tr>
</tbody>
</table>


Of the total 178,876 TBI cases since 2000, 137,328 have been mild, 30,893 have been moderate, 1,891 have been severe, 3,175 have been penetrating, and 5,589 have not been classifiable. Figure 2 shows the relative rates of mild, moderate, severe, penetrating, and not classifiable TBIs.

---

4 Defense and Veterans Brain Injury Center at http://www.dvbic.org/TBI-Numbers.aspx. The DOD categorizes TBI cases as mild, moderate, severe, or penetrating. Mild TBI is characterized by a confused or disoriented state lasting less than 24 hour; loss of consciousness for up to thirty minutes; memory loss lasting less than 24 hours; and structural brain imaging that yields normal results. Moderate TBI is characterized by a confused or disoriented state that lasts more than 24 hours; loss of consciousness for more than 30 minutes, but less than 24 hours; memory loss lasting greater than 24 hours but less than seven days; and structural brain imaging yielding normal or abnormal results. Severe TBI is characterized by a confused or disoriented state that lasts more than 24 hours; loss of consciousness for more than 24 hours; memory loss for more than seven days; and structural brain imaging yielding normal or abnormal results. A penetrating TBI, or open head injury, is a head injury in which the dura mater, the outer layer of the system of membranes that envelops the central nervous system, is penetrated. Penetrating injuries can be caused by high-velocity projectiles or objects of lower velocity, such as knives, or bone fragments from a skull fracture that are driven into the brain.
Amputations

Table 3 shows the number of individuals with amputations for OIF, OEF, and unaffiliated conflicts. The total number of amputations in all conflicts is 1,621.

<table>
<thead>
<tr>
<th>Theater</th>
<th>Type of Amputation</th>
<th>Army</th>
<th>Marine</th>
<th>Navy</th>
<th>Air Force</th>
<th>Foreign</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>OIF</td>
<td>Major Limb</td>
<td>620</td>
<td>158</td>
<td>18</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>816</td>
</tr>
<tr>
<td></td>
<td>Partial (Hand/Foot, Toes/Fingers)</td>
<td>272</td>
<td>49</td>
<td>7</td>
<td>11</td>
<td>0</td>
<td>3</td>
<td>342</td>
</tr>
<tr>
<td>OEF</td>
<td>Major Limb</td>
<td>145</td>
<td>53</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>217</td>
</tr>
<tr>
<td></td>
<td>Partial (Hand/Foot, Toes/Fingers)</td>
<td>24</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Unaffiliated Conflicts</td>
<td>Major Limb</td>
<td>94</td>
<td>12</td>
<td>25</td>
<td>31</td>
<td>1</td>
<td>26</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td>Partial (Hand/Foot, Toes/Fingers)</td>
<td>20</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,621</td>
</tr>
</tbody>
</table>

Gender Distribution of Deaths

Tables 4 and 5 provide statistics on the gender distribution of OIF and OEF casualties (also available on DOD’s website, http://siadapp.dmdc.osd.mil/personnel/CASUALTY/castop.htm). All numbers for OIF and OEF are current as of August 31, 2010. Percentages may not total 100 due to rounding. As of September 28, 2010, all six servicemembers who have died in OND were male.5

Table 4. OIF Gender Distribution of Deaths

<table>
<thead>
<tr>
<th>Gender</th>
<th>Military Deaths</th>
<th>% of Total Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4,298</td>
<td>97.5</td>
</tr>
<tr>
<td>Female</td>
<td>110</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>4,408</td>
<td>100.0</td>
</tr>
</tbody>
</table>


Table 5. OEF Gender Distribution of Deaths

<table>
<thead>
<tr>
<th>Gender</th>
<th>Military Deaths</th>
<th>% of Total Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,242</td>
<td>98.4</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>1,262</td>
<td>100.0</td>
</tr>
</tbody>
</table>


Race/Ethnicity Distribution of Deaths

Tables 6 and 7 provide statistics on the race and ethnicity distribution of OIF and OEF casualties (also on DOD’s website, http://siadapp.dmdc.osd.mil/personnel/CASUALTY/castop.htm). All numbers for OIF and OEF are current as of September 4, 2010. Percentages may not total 100 due to rounding. As of September 28, 2010, four servicemembers who have died in OND were white and two were black or African American.6

6 Ibid.
Table 6. OIF Race/Ethnicity Distribution of Deaths

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Military Deaths</th>
<th>% of Total Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>42</td>
<td>1.0</td>
</tr>
<tr>
<td>Asian</td>
<td>82</td>
<td>1.9</td>
</tr>
<tr>
<td>Black or African American</td>
<td>429</td>
<td>9.7</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>466</td>
<td>10.6</td>
</tr>
<tr>
<td>Multiple races, pending, or unknown</td>
<td>48</td>
<td>1.1</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>51</td>
<td>1.2</td>
</tr>
<tr>
<td>White</td>
<td>3,290</td>
<td>74.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,408</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


Table 7. OEF Race/Ethnicity Distribution of Deaths

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Military Deaths</th>
<th>% of Total Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>17</td>
<td>1.3</td>
</tr>
<tr>
<td>Asian</td>
<td>19</td>
<td>1.5</td>
</tr>
<tr>
<td>Black or African American</td>
<td>90</td>
<td>7.1</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>100</td>
<td>7.9</td>
</tr>
<tr>
<td>Multiple races, pending or unknown</td>
<td>14</td>
<td>1.1</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>14</td>
<td>1.1</td>
</tr>
<tr>
<td>White</td>
<td>1,008</td>
<td>80.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,262</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


**Self-Inflicted Wounds**

According to DOD’s casualty website, as of August 31, 2010, 216 servicemembers have died of self-inflicted wounds while serving in OIF and 44 have died of self-inflicted wounds while serving in OEF. No information is yet available concerning cause of death for the six servicemembers who have died in OND.

Medical Evacuation Statistics for U.S. Military Personnel


Operation Iraqi Freedom

According to DOD, a total of 49,390 individuals were medically evacuated from OIF from March 19, 2003, to August 31, 2010. Of the total number of medical evacuations, 40,436 were non-hostile-related medical air transports, and the remaining 8,954 were for servicemembers who were wounded in action. Percentages may not total 100 due to rounding.

<table>
<thead>
<tr>
<th>Table 8. OIF Medical Reasons for Evacuations (as of August 31, 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Wounded in Action</td>
</tr>
<tr>
<td>Non-Hostile Injuries(^a)</td>
</tr>
<tr>
<td>Disease/Other Medical</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>


\(^a\) The Department of Defense defines a “non-hostile injury” as an injury that is not directly attributable to hostile action or terrorist activity, such as casualties due to the elements, self-inflicted wounds, or combat fatigue.

Operation Enduring Freedom

According to DOD, a total of 13,851 individuals were medically evacuated from OEF from October 7, 2001, through August 31, 2010. Of the total number of medical evacuations, 11,063 were non-hostile-related medical air transports, and the remaining 2,788 were for servicemembers who were wounded in action. Percentages may not total 100 due to rounding.
Table 9. OEF Medical Reasons for Evacuation
(as of August 31, 2010)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Wounded in Action</td>
<td>2,788</td>
<td>20.1%</td>
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<tr>
<td>Non-Hostile Injuriesa</td>
<td>2,771</td>
<td>20.0%</td>
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<tr>
<td>Disease/Other Medical</td>
<td>8,292</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13,851</td>
<td>100%</td>
</tr>
</tbody>
</table>


a. The Department of Defense defines a “non-hostile injury” as an injury that is not directly attributable to hostile action or terrorist activity, such as casualties due to the elements, self-inflicted wounds, or combat fatigue.

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Veterans more likely to be homeless, study says

By William M. Welch, USA TODAY
Updated 2/10/2011 6:29:21 AM

Military veterans are much more likely to be homeless than other Americans, according to the government's first in-depth study of homelessness among former servicemembers.

About 16% of homeless adults in a one-night survey in January 2009 were veterans, though vets make up only 10% of the adult population.

More than 75,000 veterans were living on the streets or in a temporary shelter that night. In that year, 136,334 veterans spent at least one night in a homeless shelter — a count that did not include homeless veterans living on the streets.

The urgency of the problem is growing as more people return from service in Iraq and Afghanistan. The study found 11,300 younger veterans, 18 to 30, were in shelters at some point during 2009. Virtually all served in Iraq or Afghanistan, said Mark Johnston, deputy assistant secretary for special needs at the Department of Housing and Urban Development (HUD).

"It's an absolute shame," he said.

President Obama has set a goal of ending chronic homelessness of veterans and others by 2015.

"This report offers a much clearer picture about what it means to be a veteran living on our streets or in our shelters," HUD Secretary Shaun Donovan said. "Understanding the nature and scope of veteran homelessness is critical if we hope to meet President Obama's goal of ending this national tragedy within five years."

HUD, Veterans Affairs and the Labor Department have begun a homelessness-prevention test project in five communities near military installations. HUD is providing $10 million in short-term rental assistance, the VA is providing $5 million for medical services and case management, and the Labor Department is providing job training and counseling.

The findings about homeless veterans are in a joint analysis by HUD and the VA. The report, a copy of which was obtained by USA TODAY, is a follow-up to HUD's report on homelessness last year.

The typical vet in a shelter is...

- **Male:** 93%
- **White, non-Hispanic:** 49%
- **Age:** 31-50 45%
- **Disabled:** 52%

*Source: HUD, VA*

The report analyzed data from a nationwide homeless survey conducted around the country on one night in January 2009 and a second study looking at who falls into and out of homelessness over the course of a year.

Of the 75,609 homeless veterans found on a single night in January 2009, 43% were living on the streets without shelter, and 57% were staying in an emergency shelter or transitional housing. Nearly half were in California, Texas, New York or Florida.

Other findings:
- **Minorities are more likely to be homeless.** Of all vets in shelters, 34% were African-American, and 11% were Hispanic. By comparison, 10.5% of all veterans are African-American, and 5.2% are Hispanic.
- **Veterans stayed in shelters longer, on average, than non-veterans.** The median length of stay for single veterans was 21 days, while non-veterans stayed for 17 days.
- **Most homeless veterans, 96%, are alone rather than part of a family.** Among all homeless people, 66% are without families.
- **The 136,334 veterans who spent at least one night in a shelter during the year studied amount to one of every 168 veterans in the USA and one of every 10 veterans living in poverty.**
More women falling into ranks of homeless veterans

**More women falling into ranks of homeless veterans**

*Though they didn't have direct combat roles in Iran and Afghanistan, they suffer many of the stresses that plague male vets — often while trying to raise children alone.*

October 23, 2011 | By David Zucchino, Los Angeles Times

Reporting from Fayetteville, N.C — As a soldier, Ruth Donaldson was an accomplished ammunition specialist. As a civilian, she became a stressed-out single mother struggling to find a job and raise her child.

After a five-year stint in the Army, Donaldson lost her job at a gas station. She couldn't pay her rent. She and her 6-year-old son ended up living in a Pontiac Grand Am, hungry, homeless and exhausted.

Women make up a growing number of homeless veterans, a group usually associated with combat-hardened men unable to cope with civilian life. Homelessness among female veterans of the Iraq and Afghanistan wars has increased every year for the last six years — from 150 in 2006 to 1,700 this year — according to the Department of Veterans Affairs.

"It just seemed like it was one thing after the other, and I got so far down it was hard to come out of it," said Donaldson, who moved last month into a shelter for female veterans in Fayetteville.

Female veterans contend with the same stresses that can lead to homelessness among male veterans — brain injuries, drug and alcohol abuse, and post-traumatic stress disorder, or PTSD. But many women also contend with sexual trauma, domestic abuse and pregnancy — often while trying to raise children alone.

The VA, which has made ending homelessness a priority, says 1 in 5 female veterans report sexual trauma in the military, compared with 1 in 100 men.

Stephanie Felder, homeless program coordinator for the VA in Fayetteville, outside Ft. Bragg, says 18% of homeless veterans assisted this year are women.

"It's often a slippery slope of one thing leading to another, and their circumstances just overwhelm them and they end up homeless," Felder said.

Dasia Handy, 23, arrived pregnant and homeless with an 18-month-old son at Jubilee House, a private center. Handy served four years as an Army chemical operations specialist before leaving last year.

"People don't realize the impact of being homeless," Handy said. "All the normal things you count on in your life are suddenly gone, and you're hung out there, all on your own."

Jubilee House was founded by Barbara Marshall, a former Navy chaplain who had readjustment problems when she left active duty. In 2006, Marshall opened her home to homeless female veterans.

Last year, she bought a foreclosed, three-bedroom, 1,300-square-foot home to help house a growing number of homeless women. Last summer, with help from Ft. Bragg soldiers and the TV show "Extreme Makeover: Home Edition," the house was torn down and replaced by a new eight-bedroom, 5,000-square-foot facility.

Five formerly homeless female veterans live there with their children.

"These are smart, highly trained, highly skilled women with a lot of invisible scars," Marshall said. "All they need is a little help and encouragement."

Since 2006, the VA has helped almost 3,000 homeless female veterans among the 24,000 homeless veterans from the two wars. The numbers do not include homeless veterans who have not contacted the VA.

Overall, about 76,000 veterans are homeless in the U.S. on a given night, according to a Department of Housing and Urban Development report. (About 11% of all homeless veterans are in Los Angeles.) During 2009, nearly 136,000 veterans spent at least one night in a homeless shelter.

Veterans make up 8% of the U.S. population, but almost 16% of homeless adults. Half of all homeless veterans suffer from mental illness, and two-thirds are substance abusers, the VA said.

The VA offers a range of benefits, including medical care and education assistance. The agency also helps homeless veterans with housing, substance abuse and PTSD treatment, child care, employment and education. More than 400 formerly homeless vets have been hired and trained to help others find jobs.

But some don't apply for benefits. Others aren't aware they're eligible.

"They just assume they aren't eligible because they didn't get shot at," said Ed Drohan of the VA in Fayetteville. Any honorably discharged veteran is eligible, he said.

Though women do not serve in direct combat roles, all troops in Afghanistan and Iraq are vulnerable to enemy attack in wars with no front lines. Roadside bombs and insurgents kill and wound support troops as well as combat troops. Among veterans from those wars, about a quarter have PTSD or depressive...
disorder, and about a fifth are substance abusers.

Donaldson said she was diagnosed with PTSD, even though she did not serve in combat. She moved out after her then-husband, a soldier, physically abused her, she said.

She managed to get an apartment, but after she lost her gas station job, she couldn't afford her rent.

A friend told her about Jubilee House, where Donaldson now has a room for her and her son, Dante. The boy is enrolled in school and Donaldson has her eye on a rental house down the street. With VA housing assistance, she hopes to move in next month.

After leaving the Army while stationed in Germany last year, Dasia Handy said, she took a part-time job in a warehouse and found a nanny for her infant son. But she was injured in an accident and lost her job.

After she became pregnant in February, no one in Germany would hire her, she said. She ended up camping out at a friend’s house.

From Germany, Handy called VA offices in five states, demanding help. "The military taught me to take charge," she said.

The VA in Fayetteville referred her to Marshall, who invited her to Jubilee House. Handy arrived in August.

"She was as persistent as she could be – very determined," Marshall said.

Handy has applied for a job and for college with financial help from the VA, which also helps pay for child care. With her baby due next month, she's looking for an apartment.

"My goal" she said, "is to be out of here and back on my feet as soon as possible."

david.zucchino@latimes.com
Women's VA Health Care Falls Short

Female vets find the VA health-care system lacks the resources and initiative to care for women returning from duty

By Jan Goodwin (undated)

Tia Christopher can still see the face — "it was hard, cold," she says — of the sailor who raped her in her barracks just two months after she began training at the Defense Language Institute in Monterey, CA, in 2001. Christopher was studying to be a naval cryptologist, specializing in creating and translating Arab-language codes. She'd had two dates with the man; on one, they'd attended a Bible study class together, "which was why I trusted him," she says. And while they had kissed, they'd never had sex; indeed, Christopher was a virgin and, at 19, "pretty naive," she says.

After an evening of watching movies with friends, Christopher had returned to her room and was nearly asleep when her assailant barged in, climbed into her bed, and, despite her crying and pleading for him to stop, raped her. "My head kept banging into the concrete wall," says Christopher, who — after the man finally left — frantically washed her sheets and then curled up on the shower floor, letting the water run over her.

While the rape was horrific, what followed may be worse. Fearing reprisal, Christopher didn't report the attack. She had been sharing drinks with her friends and knew she could be severely punished, even demoted, for underage drinking. Two weeks later, however, she heard about another woman who had been assaulted by the same man. She herself was unraveling at that point, and "I knew I had to say something," says Christopher. But the military policewoman who took her story wouldn't allow Christopher to write her own statement, only to give it to her verbally. Her report stated that Christopher had had consensual sex and that, because of a lovers' quarrel, she had changed her mind afterward and claimed it was rape. Christopher was furious, but she knew there was nothing she could do. This was the military — you had to go along with the command. Then she was brought to speak with her commanding officer, who said that she was the third woman in the unit to report rape by a service member that week. "Do you females think it's a game?" he asked.

Christopher contacted first a military, then a civilian, lawyer; both told her that because there was no physical evidence, there was nothing they could do for her. Her rapist, who knew she had reported him, began stalking her, trying to intimidate her. Although he spoke to her only once, "he was everywhere," says Christopher. Her life became so miserable — other men were harassing her as well — that she left the Navy and retreated to her grandmother's house in Washington State. "For a month, I lay on her couch, curled up in a fetal ball," she says.
Several months later, Christopher sought help at a VA medical center in Seattle. She had no papers with her, and at first, no one believed she was even a veteran. "They assumed I was someone's granddaughter or wife," Christopher says. Then a clerk told her she wasn't eligible for benefits because she had served only one year. "It's a good thing my grandmother read the newspaper," says Christopher, "because she'd seen an article about a woman who, in a case of military sexual trauma, got benefits after one year" — something no one seemed to have told the clerk. "I had to yell a lot, but finally, someone from the psychology department came down."

Many of the therapists working at VA hospitals are social work or psychology students doing rotations through the VA as part of their graduate programs. "Counselors may have no connection to the military," Christopher says, "no understanding of what's different for females in the VA." That's how Christopher felt about her first therapist, a civilian woman.

What's more, the atmosphere at the mental-health center was hardly therapeutic. "You have to walk past ogling male vets, sit in waiting rooms with men who have mental problems," she says. Indeed, Christopher became so fed up that, although she was still having problems, she left therapy in 2005 and didn't return until 2008, when she was overcome by panic attacks and insomnia. "I have no option. If you're a woman vet with military sexual trauma, your only hope of finding someone who understands your experience is at the VA," says Christopher, who now serves as the women veterans coordinator for Swords to Plowshares, a San Francisco-based group that advocates for veterans.

The Military Fires Back

The Department of Defense is not unaware of these problems; if nothing else, it's bad PR. In 2005, the agency formed the Sexual Assault Prevention and Response Office (SAPRO) in hopes of making it easier for women to come forward. The government's statistics suggest that the number of women who experience rape or attempted rape in the military is roughly double the civilian rate.

These attacks are not carried out by the enemy, but by fellow service members. However, by the Pentagon's own estimate, fewer than 10 percent of sexual attacks in the military are reported each year. In part, this is because many are perpetrated by peers or higher-ranked service members against lower-ranked ones. Women are often too intimidated to name a superior, and may also worry about seeming disloyal. "The military is a culture where it is deemed dishonorable and conduct unbecoming to inflict reputational damage," explains Elizabeth Hillman, Ph.D., J.D., professor of law at the University of California Hastings College of the Law in San Francisco. "Many...think it is more important to protect the reputation of the force, and of the soldier concerned, than it is to prosecute rape."

There's another reason, too, that women keep quiet: fear of retaliation. When Keri Christensen, 36, a National Guard sergeant stationed in Kuwait (and a wife and mom with two little girls back in Wisconsin), reported that her superior had made sexual advances, she was court-martialed for drinking alcohol on duty. "I thought I was going crazy," says Christensen, who, despite having had a negative Breathalyzer test, was ultimately demoted two ranks. She was also reassigned — to duty at the Kuwait airport, near the theater mortuary where coffins of killed soldiers were loaded onto planes heading home. "My commanding officer said that this wasn't because I'd complained about harassment, but everyone around me knew it was," notes Christensen.

Because it can be so harrowing to report a sexual attack, women contacting SAPRO can make restricted and confidential reports, which means that, while they can get treatment, their assault won't be investigated — and the attacker will likely never be brought to justice. "We felt it was most important to help victims come forward to get the help they need," explains SAPRO's director, Kaye Whitley, Ed.D., who observes that more than 2,600 service members have reported sexual attacks without naming names since they've been able to do so — victims who otherwise would likely have kept silent.

As for the help they get, treatment for military sexual trauma at VA hospitals remains uncertain at best. Part of the problem may be the shortage of mental-health professionals generally. Often, too, vets confront a staff that seems stuck in the era of Vietnam — uncomfortable dealing with women, much less victims of sexual assault.

The insensitivity of some VA staffers is staggering. In testimony before the House Committee on Veterans' Affairs last July, Bhagwati, executive director of Service Women's Action Network, told the story of a woman who, while having her annual checkup and Pap smear at the local VA hospital, asked to have a female present in the exam

"Women’s VA Health Care," Jan Goodwin
room (as VA policy requires) and explained to the male gynecologist that she suffered from military sexual trauma. Leaving the room, the doctor barked down the hall, "We've got another one!"

And there are more basic problems as well. By directive, VA staff are encouraged to give vets being treated for post-traumatic stress disorder and military sexual trauma the option of a same-sex counselor when clinically indicated. But it's not required, so such a request can be ignored. What's more, there simply may not be enough female therapists. One survey found that some VA centers have few or none at all, so only 6.7 percent of women can be assured a same-sex counselor, another 8.2 percent will almost certainly be assigned to a male, and for the remainder it varies widely.

Nor can women always get into an all-female therapy group. Like the former Army reservist from Minnesota, Aston Tedford, 27, who served in Afghanistan from November 2002 to August 2003, found herself the sole female in a PTSD group in Ohio. "When I tried to talk, I was always being shut down by the male vets."

Even inpatient facilities for mental-health care often overlook women's needs. In her testimony for the House, Bhagwati cited the case of a troubled Iraq war veteran who checked herself into a California VA psychiatric unit and was forced to share a bathroom with male veterans, including a Peeping Tom. When the Minneapolis vet, hospitalized during a particularly rough time, reported that she'd been threatened by one of the male patients on the ward, a doctor replied, "Sorry, we don't have programs for women."

The Government Accountability Office (GAO), the investigative arm of Congress, examined 19 VA medical facilities in 2008 and 2009. In testimony released last July, it found that 88 percent of the facilities served women in mixed-gender inpatient psychiatric units, mixed-gender residential treatment programs, or both. Women vets weren't even guaranteed private bathing facilities. Some bathrooms lacked locks, making it possible for male patients to intrude while a woman showered or used the restroom. The GAO's conclusion: Not one of the hospitals or outpatient clinics it visited was complying fully with federal privacy requirements.

Case Study: Captain Dawn Halfaker

The mission: While on night patrol in 2004 in Iraq's dangerous Sunni Triangle, Halfaker was struck by a rocket-propelled grenade. It tore off her right arm, shattered her shoulder, smashed her ribs, burned her face, bruised her lungs, and peppered her body with shrapnel. Halfaker's injuries were so severe she was medevaced to Germany, then the U.S., where she was kept in a medical coma for 10 days.

A dream lost: When she woke up — at Walter Reed Army Medical Center in Washington, DC — her parents told her she had lost her right arm and shoulder. Halfaker, who was right-handed, had been a basketball player at West Point and had considered trying out for the Women's National Basketball Association. Instead, "I saw that bandage where my arm used to be. I didn't want to believe it," she says.

Adding insult to injury: After nearly a year, Halfaker left Walter Reed, which is not part of the VA and where her treatment had been excellent. She then entered the regular system at a VA medical center in Washington, DC. The first doctor she saw there assumed she couldn't have been in direct combat and expressed surprise that she'd lost an arm in Iraq. "Even though women are flooding the system, they're still unaccustomed to dealing with us," says Halfaker. Her care was disorganized; she had to return multiple times to get basic treatment for her shrapnel injuries. "The VA acted like they'd never seen shrapnel wounds before," she says. "They didn't even know that these are skin wounds and that I needed to see a dermatologist, not an orthopedist."

A warrior again: Today, Halfaker runs her own successful national-security consulting company and serves on the board of the Wounded Warrior Project, a group that offers support and training programs to severely injured service members. And she's a passionate advocate for women in the military: There has to be "an aggressive approach," she told Congress last spring, "to eliminating the barriers" that keep women vets from getting help.
A Veteran’s Death, the Nation’s Shame

By NICHOLAS D. KRISTOF

HERE’S a window into a tragedy within the American military: For every soldier killed on the battlefield this year, about 25 veterans are dying by their own hands.

An American soldier dies every day and a half, on average, in Iraq or Afghanistan. Veterans kill themselves at a rate of one every 80 minutes. More than 6,500 veteran suicides are logged every year — more than the total number of soldiers killed in Afghanistan and Iraq combined since those wars began.

These unnoticed killing fields are places like New Middletown, Ohio, where Cheryl DeBow raised two sons, Michael and Ryan Yurchison, and saw them depart for Iraq. Michael, then 22, signed up soon after the 9/11 attacks.

“I can’t just sit back and do nothing,” he told his mom. Two years later, Ryan followed his beloved older brother to the Army.

When Michael was discharged, DeBow picked him up at the airport — and was staggered. “When he got off the plane and I picked him up, it was like he was an empty shell,” she told me. “His body was shaking.” Michael began drinking and abusing drugs, his mother says, and he terrified her by buying the same kind of gun he had carried in Iraq. “He said he slept with his gun over there, and he needed it here,” she recalls.

Then Ryan returned home in 2007, and he too began to show signs of severe strain. He couldn’t sleep, abused drugs and alcohol, and suffered extreme jitters.

“He was so anxious, he couldn’t stand to sit next to you and hear you breathe,” DeBow remembers. A talented filmmaker, Ryan turned the lens on himself to record heartbreaking video of his own sleeplessness, his own irrational behavior — even his own mock suicide.

One reason for veteran suicides (and crimes, which get far more attention) may be post-traumatic stress disorder, along with a related condition, traumatic brain injury. Ryan suffered a concussion in an explosion in Iraq, and Michael finally had traumatic brain injury...
diagnosed two months ago.

Estimates of post-traumatic stress disorder and traumatic brain injury vary widely, but a **ballpark figure is that the problems afflict at least one in five veterans** from Afghanistan and Iraq. One study found that by their third or fourth tours in Iraq or Afghanistan, more than one-quarter of soldiers had such mental health problems.

Preliminary figures suggest that being a veteran now roughly doubles one’s risk of suicide. For young men ages 17 to 24, being a veteran almost quadruples the risk of suicide, according to a study in The American Journal of Public Health.

Michael and Ryan, like so many other veterans, sought help from the Department of Veterans Affairs. Eric Shinseki, the secretary of veterans affairs, declined to speak to me, but the most common view among those I interviewed was that the V.A. has improved but still doesn’t do nearly enough about the suicide problem.

“It’s an epidemic that is not being addressed fully,” said Bob Filner, a Democratic congressman from San Diego and the senior Democrat on the House Veterans Affairs Committee. “We could be doing so much more.”

To its credit, the V.A. has established a suicide hotline and appointed suicide-prevention coordinators. It is also chipping away at a warrior culture in which mental health concerns are considered sissy. Still, veterans routinely slip through the cracks. Last year, the United States Court of Appeals in San Francisco excoriated the V.A. for “unchecked incompetence” in dealing with veterans’ mental health.

Patrick Bellon, head of **Veterans for Common Sense**, which filed the suit in that case, says the V.A. has genuinely improved but is still struggling. “There are going to be one million new veterans in the next five years,” he said. “They’re already having trouble coping with the population they have now, so I don’t know what they’re going to do.”

Last month, the V.A.’s own inspector general reported on a 26-year-old veteran who was found wandering naked through traffic in California. The police tried to get care for him, but a V.A. hospital reportedly said it couldn’t accept him until morning. The young man didn’t go in, and after a series of other missed opportunities to get treatment, he stepped in front of a train and killed himself.

Likewise, neither Michael nor Ryan received much help from V.A. hospitals. In early 2010, Ryan began to talk more about suicide, and DeBow rushed him to emergency rooms and
pleaded with the V.A. for help. She says she was told that an inpatient treatment program had a six-month waiting list. (The V.A. says it has no record of a request for hospitalization for Ryan.)

“Ryan was hurting, saying he was going to end it all, stuff like that,” recalls his best friend, Steve Schaeffer, who served with him in Iraq and says he has likewise struggled with the V.A. to get mental health services. “Getting an appointment is like pulling teeth,” he said. “You get an appointment in six weeks when you need it today.”

While Ryan was waiting for a spot in the addiction program, in May 2010, he died of a drug overdose. It was listed as an accidental death, but family and friends are convinced it was suicide.

The heartbreak of Ryan’s death added to his brother’s despair, but DeBow says Michael is now making slow progress. “He is able to get out of bed most mornings,” she told me. “That is a huge improvement.” Michael asked not to be interviewed: he wants to look forward, not back.

As for DeBow, every day is a struggle. She sent two strong, healthy men to serve her country, and now her family has been hollowed in ways that aren’t as tidy, as honored, or as easy to explain as when the battle wounds are physical. I wanted to make sure that her family would be comfortable with the spotlight this article would bring, so I asked her why she was speaking out.

“When Ryan joined the Army, he was willing to sacrifice his life for his country,” she said. “And he did, just in a different way, without the glory. He would want it this way.”

“My home has been a nightmare,” DeBow added through tears, recounting how three of Ryan’s friends in the military have killed themselves since their return. “You hear my story, but it’s happening everywhere.”

We refurbish tanks after time in combat, but don’t much help men and women exorcise the demons of war. Presidents commit troops to distant battlefields, but don’t commit enough dollars to veterans’ services afterward. We enlist soldiers to protect us, but when they come home we don’t protect them.

“Things need to change,” DeBow said, and her voice broke as she added: “These are guys who went through so much. If anybody deserves help, it’s them.”
Guard, Reserve suicide rate sees big spike

Posted : Wednesday Jan 19, 2011 19:35:26 EST

The active-duty soldier suicide rate dropped slightly from 2009, and now service officials are focusing their attention on providing better services to guardsmen and reservists

By Michael Hoffman - Staff writer

Army officials continue to struggle to figure out why soldiers — especially the service’s citizen soldiers — keep committing suicide in record numbers, as 2010 was the sixth consecutive year the Army’s suicide rate increased.

Despite the rise, there was some progress: The active-duty suicide rate dropped slightly, but the number of suicides in the Guard and Reserve increased sharply.

In 2010, the number of suicides increased by 59, from 242 to 301, an increase of 24.4 percent. Almost twice as many guardsmen and reservists committed suicide — 145 in 2010, 80 in 2009 — as the year before. Among the active-duty force, 156 soldiers committed suicide in 2010, down from 162 in 2009.

Since 2005, 975 soldiers have committed suicide, and the Army continues to study why soldiers commit suicide and to launch prevention programs to stop it.

Deployments not the only reason

Blaming only deployments and time away from families for the increases would be incorrect, Army Vice Chief of Staff Gen. Peter Chiarelli said.

“If you think you know the one thing that causes people to commit suicide, please let us know,” he said, “because we don't know what it is.”

Of 112 guardsmen who killed themselves in 2010, more than half had not deployed.

Officials also said unemployment was not a common theme among Guardsmen and Reservists who committed suicide. About 85 percent of the guardsmen and more than half of the reservists who killed themselves had jobs, said Maj. Gen. Raymond Carpenter, the Army National Guard’s acting director.

Carpenter said the Guard is a snapshot of society and experiencing an increased suicide rate much like the rest of the nation.
“We are the canary in the mineshaft, especially the Guard, because we recruit in communities and are a reflection of those communities,” he said.

The reduction in active-duty suicides shows progress, Chiarelli said. He attributed the decrease partly to the stand-up of the service’s Health Promotion, Risk Reduction and Suicide Prevention Council and Task Force in 2009, and the programs and policy changes it’s instituted.

More soldiers are using the Comprehensive Soldier Fitness Program, and the Pain Management Task Force is monitoring the increased use of pain medication, specifically anti-anxiety drugs by soldiers, Chiarelli said. He added that more soldiers received face-to-face post-deployment behavioral health screenings.

Getting resources to part-time soldiers

Chiarelli admitted the Army has a tougher time getting the word out to reservists and guardsmen about suicide prevention programs. These soldiers have less contact with commanders and often report to their units only once a month.

Guardsmen and reservists often live in one state and are attached to units hundreds of miles away.

“I’ve got soldiers who may live in Georgia but they belong to a unit in Tennessee, so they travel a significant distance,” said Lt. Gen. Jack Stultz, chief of Army Reserves. “Having a link to them in the other 28 days of the month when they’re not there with the unit is a challenge.”

Stultz also wants more suicide prevention training for soldiers’ families. Too often not enough focus is placed on reducing the stigma for family members to reach out to their soldier’s commander or first sergeants and ask for help, he said.

“It's that family that's with the soldier the other 28 days of the month,” Stultz said. “And they’re the ones that start to see those signs, that high-risk behavior and other things.”

Service officials are focusing more attention on the needs of guardsmen and reservists. When the task force stood up in 2009, the focus was on active-duty soldiers and many of the products it produced were “one-size-fits-all,” said Col. Chris Philbrick, the task force’s deputy commander.

As Reserve and Guard leaders saw suicide rates climb this year, Army officials changed their approach and started creating Reserve- and Guard-based suicide prevention tools and programs.

Philbrick and other Army officials said they expect to see the Guard and Reserve suicide rate decline as programs have time to reach soldiers.

“Our challenge in the year ahead is to keep building upon the initial progress made in the active component,” Chiarelli said. “We’ll continue in our efforts to replicate that progress in the reserve component, primarily by expanding the reach and accessibility of the programs and services that are positively impacting the lives of soldiers serving on active duty.”
Suicide among service members and veterans challenges the health of America’s all-volunteer force. While any loss of military personnel weakens the U.S. armed forces, the rapid upswing in suicides among service members and veterans during the wars in Iraq and Afghanistan threatens to inflict more lasting harm. If military service becomes associated with suicide, will it be possible to recruit bright and promising young men and women at current rates? Will parents and teachers encourage young people to join the military when veterans from their own communities have died from suicide? Can the all-volunteer force be viable if veterans come to be seen as broken individuals? And how might climbing rates of suicide affect how Americans view active-duty service members and veterans – and indeed, how service members and veterans see themselves?

This policy brief has four objectives. First, it examines the phenomenon of suicide within the U.S. military community, including both the frequency of suicide and the extent to which suicide is related to military service. It outlines steps taken by the Department of Defense (DOD), the armed services and the Department of Veterans Affairs (VA) to reduce suicide in the armed forces and among veterans. It then identifies obstacles to reducing suicides further and makes recommendations to address each of those obstacles.

What We Know About Military Suicide

THE NUMBERS ARE STARK

From 2005 to 2010, service members took their own lives at a rate of approximately one every 36 hours.1 While suicides in the Air Force, Navy and Coast Guard have been relatively stable and lower than those of the ground forces, U.S. Army suicides have climbed steadily since 2004. The Army reported a record-high number of suicides in July 2011 with the deaths of 33 active and reserve component service members reported as suicides. Suicides in the Marine Corps increased steadily from 2006 to 2009, dipping slightly in 2010. It is impossible, given the paucity of current data, to determine the suicide rate among veterans with any accuracy. However, the VA estimates that a veteran dies by suicide every 80 minutes.2 Moreover, although only 1 percent of Americans have served during the current wars in Iraq and Afghanistan, former service members represent 20 percent of suicides in the United States.3
The U.S. military cannot avoid the stark reality of suicide entirely. Service members and veterans reflect the broader American public, which not only suffers from suicide, but also stigmatizes mental health care. Further, some service members enter military service with mental health challenges and we should not conclude that serving in the military caused these suicides. For instance, 31 percent of Army suicides are associated with factors from the years prior to entering the Army.4

ADDRESSING THE PROBLEM OF MILITARY SUICIDE REQUIRES UNDERSTANDING SUICIDE ITSELF AS WELL AS THE RELATIONSHIP BETWEEN SUICIDE AND MILITARY SERVICE

Although the number of military suicides has increased since the start of the wars in Afghanistan and Iraq, the prevailing wisdom has been that suicides are not linked directly to deployment.5 However, recent analysis of Army data demonstrates that soldiers who deploy are more likely to die by suicide.6

Data have long indicated definitive links between suicide and injuries suffered during deployment. Individuals with traumatic brain injury (TBI), for instance, are 1.5 times more likely than healthy individuals to die from suicide.7 Additional factors that heighten risk include chronic pain and post-traumatic stress disorder (PTSD) symptoms such as depression, anxiety, sleep deprivation, substance abuse and difficulties with anger management.8 These factors are also widely associated with deployment experience in Afghanistan and Iraq.

SOME PSYCHIATRIC EXPERTS ARGUE THAT THERE IS AN INDIRECT RELATIONSHIP BETWEEN SUICIDE AND MILITARY SERVICE DURING WARTIME

One school of thought, known as the interpersonal-psychological theory of suicide, suggests that the following three “protective” factors preclude an individual from killing oneself: belongingness, usefulness and an aversion to pain or death.9 Any one of these protective factors normally is sufficient to prevent suicide. Traditionally, military service has had a protective quality: Military service members have been less likely to die by suicide than civilians. It appears now, however, that the nature of military service – especially during wartime – may weaken all three protective factors.10 The cohesion and camaraderie of a military unit can induce intense feelings of belonging for many service members. Time away from the unit, however, may result in a reduced or thwarted sense of belonging, as individuals no longer have the daily support of their units and feel separate and different from civilians. This is especially true for Guardsmen and Reservists.

The responsibility inherent in military service, the importance of tasks assigned to relatively junior personnel and the high level of interaction among unit members establish the importance and usefulness of each unit member, particularly in an operational environment. In contrast, the experience of living in a garrison environment (for active component personnel) or returning to a civilian job (for Guardsmen, Reservists and veterans) or, worse, unemployment, can introduce feelings of uselessness. Individual accounts of military suicide both in the media and in interviews with us echo this sentiment. Over and over, these accounts show that individuals withdrew, felt disconnected from their units and their families, and perceived themselves as a burden.

“Commit Suicide”
The authors of this report refrain from using the phrase “commit suicide.” The word “commit” portrays suicide as a sin or a crime, as those acts are typically “committed.” This language contributes to a stigma that prevents individuals from getting help.

The BBC takes a similar stance. See www.bbc.co.uk/editorialguidelines/page/guidelines-harm-suicide for more information.
The third protective factor – an aversion to pain or death – is especially important in considering military suicide, because military service is one of the few experiences that can override this factor. Repeated exposure to military training as well as to violence, aggression and death dulls one’s fear of death and increases tolerance for pain. Thus, the very experience of being in the military erodes this protective factor, even for service members who have not deployed or experienced combat, in part because service members experience pain and discomfort from the beginning of their training. By removing some of the protective factors of suicide, therefore, military service, especially during wartime, may predispose an individual toward suicide.

### Efforts and Obstacles

**LEADERS IN THE ARMED SERVICES AND THE VA DESERVE RECOGNITION FOR THEIR ACTIONS TO REDUCE THE RATE OF SUICIDE AMONG SERVICE MEMBERS AND VETERANS, BUT FACE PERSISTENT OBSTACLES**

Senior military leaders have exerted considerable effort in recent years to acknowledge and confront the challenge of suicide. The VA and each of the military services have emphasized the development of suicide prevention programs, education about the risk of suicide and the most effective ways to prevent it. The DOD suicide prevention programs, with slogans such as “Never Leave a Marine Behind” and “Never Let Your Buddy Fight Alone,”
resonate with service members by being service-specific and embedded in their service cultures. The services ensure that the necessary tools, such as hotlines, are readily available. The VA’s Veterans Crisis Line is especially important in this regard. In its first three years, the hotline received more than 144,000 calls involving veterans and saved more than 7,000 actively suicidal veterans. Obstacles remain nonetheless.

MILITARY PERSONNEL TRANSFERS COMPlicate Efforts to Help Individuals Struggling with Mental Health Issues

Permanent change of station (PCS) moves are a feature of military life. Yet, such moves make it difficult for unit leaders to recognize and understand the unique mental health issues of their people, and for service members and military family members to obtain consistent mental health care. When military personnel arrive at a new unit, unit leaders are often unaware of particular service members’ personal challenges. Further, because professional organizations license mental health care providers on a state-by-state basis, a geographical move across state lines can preclude continued care from the same provider. When a care provider and a service member (or a military family member) invest in developing a care relationship, and that relationship is severed by a move, patients are often reluctant to begin treatment anew.

Recommendation: The services need to ensure that information about a service member’s mental health well-being is transferred when that individual moves. When a unit commander has significant concerns regarding a departing member, he or she should discuss these issues with the receiving commander. Congress should establish a federal pre-emption of state licensing such that mental health care can be provided across state lines for those instances in which military service members or family members have an established pre-existing care relationship.

ARMY PERSONNEL TRANSFERS OCCur Too Soon AfTer Deployment

Army units returning home from deployment experience tremendous turnover, as individuals leave the unit for their next assignments. Because rotations do not occur immediately prior to or during deployments, individuals typically transfer to their next assignments during the post-deployment time frame. This lack of unit stability following a deployment has unfortunate implications for individuals struggling with reintegration. Leaders most familiar with the troops and most likely to recognize atypical or risk-taking behavior are gone. New leaders are less likely to interpret misbehavior by otherwise good soldiers as a warning sign. Recognizing the importance of unit stability, the Marine Corps has directed that Marines must remain assigned to their deploying unit for 90 days following deployment.

Recommendation: The Army should establish a unit cohesion period following deployment.

COMMANDERS Are NOT Always Aware When Subordinates Are the Subject of an Investigation

A significant number of suicide victims were coping with legal problems. Yet, even though the notification of a criminal investigation is sometimes a suicide trigger, criminal investigators do not usually contact commanders when they inform a service member that he or she is the subject of an investigation. The Air Force has recognized this phenomenon and now coordinates its investigators and commanders more effectively. Air Force guidance underscores that the investigating agency and unit leaders share responsibility for the safety and well-being of individuals under investigation. Further, if individuals appear emotionally distraught or agitated, investigators will release them only to unit leaders. Army investigators began informing commanders of individual investigations in 2011, but this practice is not followed consistently. Other services’ investigators do not regularly involve commanders.
Recommendation: The Army, Navy, Marine Corps and Coast Guard should ensure that investigators inform unit commanders of ongoing investigations, and that investigators work with unit leaders to ensure the safety and well-being of members under investigation.

THE MENTAL HEALTH SCREENING PROCESS FOLLOWING DEPLOYMENT IS FLAWED
As service members return home from deployment, they complete a post-deployment health assessment (PDHA). As part of this assessment, they are asked questions about their physical and mental health, such as, “Did you encounter dead bodies or see people killed or wounded during this deployment?” and “During this deployment, did you ever feel that you were in great danger of being killed?” There are also self-evaluative questions, such as, “Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern?” While we do not question the contents of the assessment, its administration has been problematic.

A 2008 study found that when Army soldiers completed an anonymous survey, reported rates of depression, PTSD, suicidal thoughts and interest in receiving care were two to four times higher as compared to the PDHA. Likewise, our interviews with veterans uncovered numerous accounts of returning service members whose unit leaders advised them to fabricate answers. Individuals across all services have been told, “If you answer yes to any of those questions, you are not going home to your family tomorrow.” This may be factually correct, but it neglects to inform service members of the implications of answering untruthfully – namely, that they will have difficulty receiving treatment or compensation for mental health problems that appear after their service. As an improvement, the 2010 National Defense Authorization Act requires trained medical or behavioral health professionals to conduct the PDHA evaluations individually and face-to-face, in the hope that service members will respond honestly to a trained health professional.

Recommendation: Unit leaders should encourage members to complete the PDHA truthfully and should underscore that a truthful answer will allow them to link any future mental health problems requiring treatment to their military service.

A CULTURAL STIGMA ATTACHED TO MENTAL HEALTH CARE PERSISTS IN THE ARMED SERVICES
The health and survival of service members hinges on the removal of the stigma associated with mental health care. This stigma exists in both military and civilian culture. In the military, it prevents many service members from seeking help to address mental health care issues; 43 percent of soldiers, sailors, airmen and Marines who took their own lives in 2010 did not seek help from military treatment facilities in the month before their deaths. The percentage of service members seeking help has improved – from 40 percent in 2008 and 36 percent in 2009 to 57 percent in 2010 – but the stigmatization of mental health care remains an issue. Military leaders recognize the importance of removing this stigma. Indeed, recently retired Chairman of the Joint Chiefs of Staff Admiral Mike Mullen identified the stigma of PTSD as the greatest challenge confronting troops returning from war in Iraq and Afghanistan, and other DOD leaders at the highest levels have urged service members to seek mental health care as needed. Nevertheless, the stigma persists.

This culture is unlikely to change quickly. Leaders have not provided sufficient guidance about how to remove the stigma associated with depression and suicidal thoughts, and they have not consistently disciplined service members who belittle or ridicule members with mental health issues. Removing the stigma for PTSD, an invisible injury, will be especially difficult, given that some service members do not even consider
TBI, which is physically evident and recognizable, a “real injury.” Yet the stigma must be removed to address and treat PTSD and TBI, both of which are linked to suicide. Further, despite policies to provide military memorial or burial to members who die by suicide, some commanders decline to provide their families this benefit. Anecdotal accounts suggest that these commanders sometimes believe that military memorials or funerals may seem to endorse or glamorize suicide. Although isolated, such denials of military remembrance disproportionately reinforce the stigma of mental health problems, particularly when these instances receive media coverage.

**Recommendation:** Military leaders must eliminate the stigma associated with mental health care, hold unit leaders accountable for instances in which individuals are ridiculed for seeking treatment, and ensure that military funerals or memorials are provided to all otherwise eligible service members who die by suicide.

**MILITARY HAZING PERSISTS**

One to two percent of military suicides, and four to five percent of military suicide attempts, involve hazing in the unit or military workplace. This is a small percentage, but unacceptable nonetheless. In congressional testimony, senior military officers recently underscored that service policies prohibit hazing behavior. The services have also court-martialed individuals for hazing, but isolated instances persist.

**Recommendation:** Service leaders must ensure that not only their policies but also their cultures prohibit hazing and abuse, and that the armed services do not harbor abusive leaders.

**THE NUMBER OF CARE PROVIDERS IS INSUFFICIENT**

There is a national shortage of mental health care and behavioral health care professionals, a factor linked to higher rates of suicide. According to the VA, suicide rates decreased by 3.6 deaths per 100,000 in seven regions where staff numbers increased to levels recommended in the 2008 Veterans Health Administration Handbook. Sixteen regions are still not manned to these levels, however. Additionally, the Army has only 80 percent of the psychiatrists and 88 percent of the social workers and behavioral health nurses. With respect to psychologists, 93 percent of positions are filled.

Military hospital commanders have temporary authority to hire psychologists and social workers and behavioral health nurses on an as-needed basis, but a shortage of care providers precludes them from easily filling that gap. This shortage is a national issue, which affects the availability of care providers for the DOD and the VA. It also affects veterans’ families, who seek treatment from the civilian health care system to cope with the strain of reintegration.

**Recommendation:** Congress should permanently establish expedited or direct hire authority allowing military hospitals to hire behavioral health care providers.

**LEGAL RESTRICTIONS PREVENT MILITARY LEADERS FROM DISCUSSING PRIVATELY OWNED WEAPONS**

Forty-eight percent of military suicides in 2010 occurred with privately owned weapons. Multiple studies indicate that preventing easy access to lethal means, such as firearms, is an effective form of suicide prevention. However, the 2011 National Defense Authorization Act (NDAA) prohibits anyone within the DOD from “collect[ing] or record[ing] any information relating to the otherwise lawful acquisition, possession, ownership, carrying, or other use of a privately owned firearm, privately owned ammunition, or another privately owned weapon by a member of the Armed Forces or civilian employee of the Department of Defense” unless that individual lives on a military installation. The current law does allow military leaders to discuss privately owned weapons with...
service members who appear to be a threat to themselves or others, but commanders cannot ask a severely depressed individual about personally owned weapons if that individual denies that he or she is considering harming himself or herself.

**Recommendation:** Congress should rescind the NDAA 2011 restriction on discussing personally owned weapons so that unit leaders can suggest to service members exhibiting high-risk behavior, acting erratically or struggling with depression that they use gunlocks or store their guns temporarily at the unit armory. Given this change in law, unit leaders should engage both at-risk service members and their family members, and encourage them to obtain gunlocks or to store privately owned weapons out of the household.

**Leaders are best able to help their troops when they know if individuals are struggling.**

**THERE IS EXCESS PRESCRIPTION MEDICATION IN THE MILITARY COMMUNITY**

Misuse of prescription medication is another obstacle to addressing the problem of military suicide. Approximately 14 percent of the Army population is currently prescribed an opiate. Forty-five percent of accidental or undetermined Army deaths from 2006 to 2009 were caused by drug or alcohol toxicity, and 29 percent of Army suicides between 2005 and 2010 included drug or alcohol use.

Data collected from civilian populations indicate that adults aged 18-34 are the most likely to have attempted drug-related suicides, and that 58.9 percent of drug-related suicide attempts resulting in visits to an emergency room involve psychotherapeutic drugs. Another 36 percent of emergency room visits for suicide attempts involve pain medications. If we anticipate similar rates among military service members, it is important to address the excess prescription medicine among military service members. Yet, there is no opportunity to do so. When military doctors prescribe an alternative medication or dosage from what a service member was previously prescribed, there is no request made for the service member to return the remainder of his or her prior medication. Instead, military doctors dispense additional medications, because only law enforcement personnel can conduct “take-back” programs for medications. On January 26, 2011, the Army Vice Chief of Staff requested that the Drug Enforcement Administration (DEA) permit the Army’s military treatment facilities and pharmacies to accept excess prescription medicine for disposal. The request was denied.

**Recommendation:** The DEA should grant the DOD authority to accept and destroy excess prescription medication from military service members. Given this authority, the Office of the Army Surgeon General should initiate an effort with the Navy, Air Force and Coast Guard surgeon generals to develop policies and practices regarding how best to account for, and regain possession of, excess prescription medications.

**UNIT COMMANDERS HAVE LIMITED VISIBILITY INTO SERVICE MEMBERS’ MEDICAL PROBLEMS**

Leaders are best able to help their troops when they know if individuals are struggling. Yet protected health information laws have precluded medical professionals from sharing information with the chain of command. Unit leaders can better help soldiers when the commanders are aware of significant problems. Proponents of behavioral health privacy laws, however, voice concern that military personnel will not seek help if they know that commanders will be informed. Consistent with this concern, health care providers should keep most medical information private. However, when behavioral health professionals believe that an individual is at high risk for killing one’s self, they should inform the relevant commander. The Army
has recently encouraged doctors to share information with commanders when doctors observe a soldier “at potential risk to themselves.” Nonetheless, it is unclear whether military behavioral health care providers are consistently following this suggestion.

**Recommendation:** Behavioral health care providers should inform the unit commander when a service member is at high risk for suicide. The armed services should develop specific guidance for unit commanders on how to interact with individuals after receiving this information.

**INFREQUENT INTERACTION AMONG DRILLING GUARDSMEN AND RESERVISTS LIMITS UNIT LEADERS’ ABILITY TO RECOGNIZE AND HELP SUBORDINATES STRUGGLING WITH MENTAL HEALTH ISSUES**

The DOD approach to suicide prevention depends heavily on what experts refer to as “gatekeeper strategies.” The Army, for example, asserts that “[t]here is no other aspect of [its suicide prevention] that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. Leaders, supervisors, and ‘Buddies’ represent the first level for surveillance of high risk behavior.”

Although medical and academic experts identify gatekeeper approaches as one of the most promising strategies, the limitations of this approach are notable for the Guard and Reserve, where there are long monthly gaps between drill periods when leaders and peers do not have the opportunity to watch for warning signs. Yet studies indicate that even the smallest amount of contact can reduce the risk of suicide. These findings suggest that even postcards or text messages from unit leaders between drill weekends can help prevent suicides.

**Recommendation:** The DOD should address weaknesses in gatekeeper-based programs for drilling Guard and Reserve units. Specifically, Guard and Reserve units should develop a leadership communication plan that addresses the stresses on units and details the frequency and method (written, electronic or telephone) by which small unit leaders should remain in contact with their subordinates. Leaders should pay closer attention to this communication following a deployment.

**THE NATIONAL GUARD HAS TOO MANY SUICIDE PREVENTION PROGRAMS**

Assessing which suicide prevention strategies are effective requires systematic efforts to understand military suicide. Yet these efforts are thwarted by the existence of too many programs. Suicide prevention programs in the National Guard are a decentralized multitude that the Adjutant General (TAG) of each state and U.S. territory initiates and manages. This grassroots solution is inefficient given that, while some states had more suicides than others, overall the Army National Guard averages slightly more than one suicide per state annually. Although the individual programs may use evidence-based approaches, it will be difficult to demonstrate which suicide prevention programs are effective with the military community or efficacious in reducing suicide, because the small numbers do not support rigorous analysis. Even more important, these programs risk reduction or elimination due to dwindling state resources.

**Recommendation:** The National Guard should reduce the number of unique suicide prevention programs, and consider adoption of a systemwide, centrally funded, prevention approach.

**THE TRUE NUMBER OF VETERANS WHO DIE BY SUICIDE IS UNKNOWN**

Americans must have a more complete accounting of veteran suicide. The VA estimates

**The true number of veterans who die by suicide is unknown.**
that 18 veterans kill themselves every day, but this number is extrapolated from extremely limited data. Specifically, states provide death data to the Centers for Disease Control (CDC) for inclusion in the National Death Index, but only 16 of U.S. states indicate veteran status in their data. The number of veteran suicides from the remaining 34 states is extrapolated to estimate the overall number of veteran suicides. Further, the current numbers are extrapolated from three-year-old data.

An effort is underway to match the Social Security numbers in the national death data with DOD files to identify veterans included in the data. This effort provides the capability to analyze the data and characterize the veteran victims of suicide. It will thus be possible to quantify veteran suicide and contribute an understanding of the number of suicides among post-9/11 veterans, as compared with veterans of earlier generations. This analysis could also permit an understanding of whether veterans kill themselves soon after leaving the military.

The DOD does not currently take sufficient responsibility for veteran suicide. Given the potential implications of veteran suicide for the all-volunteer force, the DOD should seek to understand which veterans, and how many veterans, are dying by suicide. In particular, the DOD, as well as the VA and the country at-large, should recognize that many veterans who left the service only shortly before they killed themselves may have suffered from unaddressed mental health wounds incurred while in service to their nation.

Recommendation: Congress should establish reasonable time requirements for states to provide death data to the CDC, and the Department of Health and Human Services (HHS) should ensure that the CDC is resourced sufficiently to expedite compilation of national death data. The DOD, the VA and HHS should coordinate efforts to analyze veteran suicide data and should conduct these analyses annually.

**UNDERSTANDING AND ADDRESSING THE CHALLENGE OF SUICIDE REQUIRES COOPERATION BEYOND THE TRADITIONAL JURISDICTIONAL BOUNDARIES FOR MANY ORGANIZATIONS, INCLUDING THE DOD, THE VA, HHS AND CONGRESS**

The programs and services designed to understand and reduce service member and veteran suicide should complement one another and gain both efficiency and effectiveness from interacting synergistically. Obtaining veteran suicide data and understanding the circumstances surrounding individuals who die by suicide depends on the states and the HHS, as well as on the participation of the VA and the DOD. Within DOD, the military services and components do not regularly and consistently share information. Further, the congressional committees that hold the DOD and the VA accountable are stove-piped. The House Armed Services Committee (HASC) and the Senate Armed Services Committee (SASC) interact only with DOD and generally do not address veteran suicide issues. Likewise the Senate Committee on Veteran Affairs and the House Veterans Affairs Committee, which represent veterans’ interests, interact with the VA, not with the DOD.

**Recommendation:** The DOD, the VA and HHS should share data and information pertaining to suicide. The military services’ leaders should meet regularly to discuss issues and approaches pertaining to suicide, and to share lessons learned. The Senate Committee on Veterans Affairs and the House Veterans Affairs Committee should initiate discussions with SASC and HASC, with the intent of developing provisions for the NDAA to address the problem of veteran suicide.
Conclusion
George Washington asserted, “The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation.”

If Washington was correct, suicide among service members and veterans threatens the health of the all-volunteer force. Mentors and role models, including parents, teachers and, importantly, veterans, play a critical role in the enlistment decisions of young men and women. We should realize that these mentors and role models will not steer youth toward the military if they perceive damage to service members or a failure to address the mental health care needs of those who have served their country.

The military must take care of its own. Although a goal of no suicides may be unachievable, the increasing number of suicides is unacceptable. Additionally, although benefits and services available from the Veterans Health Administration will likely remain the best system of care for veterans, the DOD has moral responsibility to acknowledge and understand former service members.

America is losing its battle against suicide by veterans and service members. And, as more troops return from deployment, the risk will only grow. To honor those who have served and to protect the future health of the all-volunteer force, America must renew its commitment to its service members and veterans. The time has come to fight this threat more effectively and with greater urgency.

Help for Service Members, Veterans and Military Families
Veterans Crisis Line: 1.800.273.TALK (8255), Press 1

This collaborative effort by the U.S. Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration meets the special needs of service members, veterans and family members in personal crisis.

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The views expressed herein are solely those of the authors.
ENDNOTES


2. Department of Veterans Affairs, Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide (March 2010).

3. Ibid.


5. This relationship has not been evident in prior analyses and is not evident in suicide data from the Navy, Air Force, Marine Corps or Coast Guard.


7. Department of Veterans Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management, “Recent VHA Findings Regarding TBI History and Suicide Risk” (October 29, 2009).


10. See the discussion of these effects in Edward A. Selby et al., “Overcoming the Fear of Lethal Injury: Evaluating Suicidal Behavior in the Military through the Lens of the Interpersonal-Psychological Theory of Suicide,” Clinical Psychology Review 30 no. 3 (April 2010), 298-307.

11. Craig J. Bryan et al., “Challenges and Considerations for Managing Suicide Risk in Combat Zones,” Military Medicine 175 no. 10 (October 2010), 713-718; and Edward A. Selby et al., “Overcoming the Fear of Lethal Injury.”


14. The commandant has directed a 90 day post-deployment cohesion period for every full deploying unit, absent approval from a general officer to move individuals.

15. Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives (August 2010), indicates that 35 percent of Navy suicides had discipline or legal problems (22), 39 percent of Air Force suicides had legal problems (23), and 43 percent of Marine suicides were pending disciplinary action (29). The Army HP/RR/SP Report indicates that 34 percent of 2009 Army suicide victims had legal issues. U.S. Army, Health Promotion Risk Reduction Suicide Prevention Report (August 2010), 24.

16. The Air Force includes such notification in their suicide prevention strategy, requiring investigators to contact, person-to-person, an airman’s commander, first sergeant or supervisor. This policy was begun in 1996, when evidence indicated that more than 30 percent of Air Force active-duty suicide victims had legal problems and were under investigation. U.S. Air Force, The Air Force Suicide Prevention Program: A Description of Program Initiatives and Outcomes, AFPM 44-160 (April 2001).

17. Christopher H. Warner et al., “Importance of Anonymity to Encourage Honest Reporting in Mental Health Screening After Combat Deployment,” Archives of General Psychiatry 68 no. 10 (October 2011), 1065-1071.


19. Fifty-seven percent of DOD suicides were seen at a military treatment facility in the month prior to their deaths. Department of Defense, Department of Defense Suicide Event Report, Calendar Year 2010 Annual Report (September 2011), 23.


22. See, for example, the following news article for a publicized account of such ridicule: http://www.q13fox.com/news/kcpp-suicide-rate-spiking-at-joint-base-lewismcchord-20110817,0,1023250.story.

23. The authors interviewed veterans who did not mention their own TBI in response to the question, “Were you physically wounded during deployment?” When interviewees mentioned TBI in subsequent conversations, they would typically explain that their initial answer only included “real injuries.”


26. MG Thomas P. Bostick, U.S. Army, Deputy Chief of Staff, G-1; RADM Anthony M. Kurtz, U.S. Navy, Director, Military Personnel, Plans and Policy; LtGen Robert E. Milstead Jr., U.S. Marine Corps, Deputy Commandant for Manpower and Reserve Affairs; and Lt Gen Darrell D. Jones, U.S. Air Force, Deputy Chief of Staff for Manpower and Personnel, each affirmed during the House Armed Services Committee hearing “Current Status of Suicide Prevention Programs in the Military,” on September 9, 2011, that their service specifically prohibits hazing. The generals and admiral were responding to a question by Congresswoman Judy Chu, whose nephew, LCpl Harry Lew, was a victim of suicide after being hazed by fellow Marines in Afghanistan.

27. The Veteran Health Administration (VHA) is a subordinate organization to the Veterans Administration. The VHA is divided into 23 regions called Veterans
Integrated Service Networks.

28. Department of Veterans Affairs, Veterans Health Administration Handbook 1160.01 (September 11, 2008).

29. Army personnel numbers are as of July 2011, from communication with Army Medical Command representative (September 29, 2011).


33. U.S. Army, Health Promotion Risk Reduction Suicide Prevention Report (August 2010), 45. Also, the Army estimates that 30,401 soldiers would test positive for a medical review officer–reviewable drug, with 3,925 representing illicit use. Ibid., 44.

34. Ibid., 45.

35. Ibid., 43.


37. Substance Abuse and Mental Health Services Administration, The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults, 6.

38. Substance Abuse and Mental Health Services Administration, The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults, 6.


40. For example, a doctor can notify a unit that an individual is taking a prescription that precludes the use of heavy machinery, but cannot tell the chain of command that the prescription is treating depression.


42. Zoroya, “Army Suicide Prevention Efforts Raising Privacy Concerns.”

43. U.S. Army, Health Promotion Risk Reduction Suicide Prevention Report, 46.

44. Mann et al., “Suicide Prevention Strategies: A Systematic Review.”

45. Alexandra Fleischmann et al., “Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries,” Bulletin of the World Health Organization 86 no. 9 (September 2008), 703-709.

46. See, for example, Mark Brunswick, “Anti-Suicide Program for Military Runs Low: Shortfall Comes as Minnesota Guard Fights High Suicide Rates,” Star Tribune; October 2, 2011.

47. Department of Veterans Affairs, Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide.

48. The states are Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia and Wisconsin.

49. Even if all states indicate veteran status, suicides will still be underreported because of the vulnerability of civilian death data to the social stigma of suicide.

50. The CDC is subordinate to the HHS.

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EMPLOYMENT SITUATION OF VETERANS — 2010

The unemployment rate for veterans who served in the military at any time since September 2001—a group referred to as Gulf War-era II veterans—was 11.5 percent in 2010, the U.S. Bureau of Labor Statistics reported today. The jobless rate for veterans of all eras combined was 8.7 percent, compared with 9.4 percent for nonveterans. About 25 percent of Gulf War-era II veterans reported having a service-connected disability in July 2010, compared with about 13 percent of all veterans.

This information was obtained from the Current Population Survey (CPS), a monthly sample survey of about 60,000 households that provides official statistics on employment and unemployment in the United States. Data about veterans are collected monthly in the CPS; those monthly data are the source of the 2010 annual averages presented in this release. In July 2010, a supplement to the CPS collected additional information about veterans on topics such as service-connected disability. Information from the supplement also is presented in this release. The supplement was co-sponsored by the U.S. Department of Veterans Affairs and by the U.S. Department of Labor’s Veterans’ Employment and Training Service. For more information, see the Technical Note, which provides definitions of terms used in this release.

Highlights from the 2010 data:

- Young male veterans (those ages 18 to 24) who served during Gulf War era II had an unemployment rate of 21.9 percent in 2010, not statistically different from the jobless rate of young male nonveterans (19.7 percent). (See table 2.)

- Male Gulf War-era II veterans ages 18 to 24 were more likely to participate in the labor force in 2010 than were their nonveteran counterparts—74.0 percent versus 67.5 percent. (See table 2.)

- Among all veterans, those with a service-connected disability had an unemployment rate of 9.1 percent in July 2010, about the same as the rate for veterans with no disability (8.7 percent). (See table 6.)

- About one-third of employed veterans with a service-connected disability worked in the public sector in July 2010; 1 in 5 veterans with a disability were employed by the federal government. (See table 7.)
- Gulf War-era II veterans who were current or past members of the Reserve or National Guard had an unemployment rate of 14.0 percent in July 2010, compared with a rate of 12.1 percent for those veterans who had not been members. (See table 8.)

Regardless of their period of service, unemployment rates in 2010 for veterans with higher levels of education were lower than for those with less education. (See table 3.)

The Veteran Population

In 2010, 20.2 million men and 1.8 million women in the civilian noninstitutional population ages 18 and over were veterans. (See table 1.) In the CPS, veterans are defined as men and women who have previously served on active duty in the U.S. Armed Forces and who were civilians at the time they were surveyed.

Veterans are more likely to be men and older than were nonveterans. In part, this reflects the characteristics of veterans who served during World War II, the Korean War, and the Vietnam era. Veterans who served during these wartime periods account for one-half (11.0 million) of the total veteran population. A total of 5.1 million veterans served during Gulf War era I (August 1990 to August 2001) or Gulf War era II (September 2001 forward). Another 5.9 million served outside the designated wartime periods. Because age and other demographic differences affect labor force status, the groups of veterans are examined separately in the next sections.

Gulf War-era II Veterans

In 2010, about 2.2 million of the nation's veterans had served during Gulf War era II. About 17 percent of these veterans were women, compared with 3 percent of veterans from World War II, the Korean War, and the Vietnam era. Nearly two-thirds of all Gulf War-era II veterans were under the age of 35. (See tables 1 and 2.)

In 2010, a large majority (82.2 percent) of Gulf War-era II veterans participated in the labor force, and their unemployment rate was 11.5 percent. For those ages 18 to 24, the unemployment rate was 20.9 percent, higher than that of Gulf War-era II veterans ages 25 to 34 (13.1 percent). In general, Gulf War-era II veterans had unemployment rates that were not statistically different from those of nonveterans of the same gender and age group. (See table 2.)

Gulf War-era II veterans were twice as likely to work in the public sector as were nonveterans—30 percent and 15 percent, respectively. About 16 percent of employed veterans of the era worked for the federal government, compared with about 2 percent of nonveterans. (See table 5.)

Veterans of Gulf War era II and nonveterans had similar occupational profiles after accounting for gender. About one-third of the men in both groups worked in management and professional occupations, a higher proportion than in any other major occupational group. Among women, 44 percent of Gulf War-era II veterans and 41 percent of nonveterans were employed in management and professional occupations. (See table 4.)

The July 2010 veterans supplement included questions to identify veterans who had served in Iraq at any time since March 2003 or in Afghanistan at any time since October 2001. In July 2010, approximately one-third of Gulf War-era II veterans reported that they had served in Iraq, Afghanistan, or both. (Some veterans did not report their location of service.) These veterans had an unemployment rate of 14.3
percent, not statistically different from Gulf War-era II veterans who served elsewhere (11.4 percent). (See table 9.)

**Gulf War-era I Veterans**

For the 2.9 million veterans who served during Gulf War era I (August 1990 to August 2001), the proportion that were men (85 percent in 2010) was similar to that of Gulf War-era II veterans. About 83 percent of the era's veterans were age 35 and over, compared with 35 percent of Gulf War-era II veterans. (See tables 1 and 2.)

The labor force participation rate of veterans from Gulf War era I was 86.5 percent in 2010, slightly higher than the rate of Gulf War-era II veterans (82.2 percent). The unemployment rate for Gulf War-era I veterans (7.7 percent) was lower than the rate for Gulf War-era II veterans (11.5 percent). These differences in labor force participation and unemployment reflect, at least in part, the older age profile of veterans who served in Gulf War era I. Unemployment rates of Gulf War-era I veterans were not statistically different from those of nonveterans of the same gender and age group.

**Veterans of World War II, the Korean War, and the Vietnam Era**

In 2010, about 11.0 million veterans had served during World War II, the Korean War, or the Vietnam era. Nearly all of these veterans were at least 55 years old, and more than half were at least 65 years old. Virtually all (97 percent) of these veterans were men. In 2010, just over one-third of male veterans of these earlier wartime periods were in the labor force, and their unemployment rate was 8.4 percent. Male veterans of these wartime periods had lower labor force participation rates compared with male non-veterans in the same age categories. (See tables 1 and 2.)

**Veterans of Other Service Periods**

In 2010, about 5.9 million veterans had served on active duty during "other service periods," mainly between the Korean War and the Vietnam era, and between the Vietnam era and Gulf War era I. Because these veterans served between the major wartime periods, which span several decades, this group has a diverse age profile. About 43 percent of these veterans were 45 to 54 years old, and another 39 percent were 65 years and over. (See tables 1 and 2.)

Nine in 10 veterans of other service periods were men. Among most age groups, male veterans of service periods between the designated wartime periods had labor force participation rates and unemployment rates that were not statistically different than those of male nonveterans.

**Veterans with a Service-connected Disability**

In July 2010, about 2.8 million veterans, or 13 percent of the total, reported having a service-connected disability. (Some veterans did not report whether they had a service-connected disability.) Veterans with a service-connected disability are assigned a disability rating by the U.S. Department of Veterans Affairs. Ratings range from 0 to 100 percent, in increments of 10 percentage points, depending on the severity of the condition. Among veterans with a service-connected disability, about 4 in 10 reported a disability rating of less than 30 percent, while about 1 in 4 had a rating of 60 percent or higher. (See table 6.)
Among veterans who served in Gulf War era II, about 1 in 4 (530,000) reported having a service-connected disability. Of these, 81.0 percent were in the labor force, compared with 86.2 percent of veterans from this period with no service-connected disability. Among Gulf War-era II veterans, the unemployment rate of those with a disability was 11.2 percent, not statistically different from those with no disability (13.6 percent).

Nineteen percent (548,000) of veterans who served during Gulf War era I reported a service-connected disability. Their labor force participation rate (75.8 percent) was lower than the rate for veterans from the era who did not have a disability (88.7 percent). Unemployment rates for Gulf War-era I veterans with and without service-connected disabilities were not statistically different (8.8 and 6.8 percent, respectively).

Among the 1.2 million veterans with a service-connected disability from World War II, the Korean War, and the Vietnam era, 26.2 percent were in the labor force in July 2010, compared with 36.5 percent of veterans from these periods who did not have a service-connected disability. The unemployment rate of veterans with a disability from these wartime periods was 10.1 percent, little different than veterans with no disability (8.6 percent).

Veterans with a service-connected disability from other service periods had a labor force participation rate of 53.5 percent, compared with 60.4 percent for veterans with no disability from these periods. The unemployment rate of veterans with a disability from other service periods was 5.1 percent, not statistically different from the veterans with no disability—8.1 percent.

Regardless of period of service, many veterans with a service-connected disability worked in the public sector. In July 2010, 35 percent of employed veterans with a disability worked in federal, state, or local government, compared with 21 percent of veterans with no disability and 14 percent of nonveterans. About 20 percent of employed veterans with a disability worked for the federal government, compared with 7 percent of veterans with no disability and 2 percent of nonveterans. (See table 7.)

**Reserve and National Guard Membership**

A smaller proportion of Gulf War-era I veterans (27 percent) were reported to be current or past members of the Reserve or National Guard than Gulf War era-II veterans (32 percent). Among Gulf War-era II veterans, those who were current or past members of the Reserve or National Guard had an unemployment rate of 14.0 percent in July 2010, compared with 12.1 percent for those who had never been members. Labor force participation rates did not differ significantly by Reserve or National Guard membership for Gulf War-era II veterans. For veterans of Gulf War era I, labor force participation rates as well as unemployment rates were similar for Reserve or National Guard members and nonmembers. (See table 8.)
Technical Note

The data in this release were collected through the Current Population Survey (CPS). The CPS—a monthly survey of about 60,000 households conducted by the U.S. Census Bureau for the Bureau of Labor Statistics—obtains information on employment and unemployment among the nation's civilian noninstitutional population age 16 and over.

Most of the data in this release are annual averages for 2010, compiled from the results of the monthly survey. Some of the data, such as those related to service-connected disability and Reserve or National Guard status, are from special questions asked as part of the latest veterans supplement to the CPS, which was conducted in July 2010. The supplement was co-sponsored by the U.S. Department of Veterans Affairs and by the U.S. Department of Labor's Veterans' Employment and Training Service. Questions were asked of persons 17 years of age and older regarding their prior service in the U.S. Armed Forces. Data are tabulated for persons 18 years of age and older.

Information in this release will be made available to sensory impaired individuals upon request. Voice phone: (202) 691-5200; Federal Relay Service: (800) 877-8339.

Definitions

The definitions underlying the data in this release are as follows:

Veterans are men and women who previously served on active duty in the U.S. Armed Forces. Members of the Reserve and National Guard are counted as veterans if they had ever been called to active duty. Persons who are on active duty at the time of the survey are outside the scope of the survey and thus not in the estimates shown here, as are persons who reside in institutions, such as nursing homes and prisons.

Nonveterans are men and women who never served on active duty in the U.S. Armed Forces.

World War II, Korean War, Vietnam-era, and Gulf War-era veterans are men and women who served in the Armed Forces during these periods, regardless of where they served. Veterans who served in more than one wartime period are classified in the most recent one.

Veterans of other service periods are men and women who served in the Armed Forces at any time other than World War II, the Korean War, the Vietnam era, or the Gulf War era. Although U.S. Armed Forces were engaged in several armed conflicts during other service periods, these conflicts were more limited in scope and included a smaller proportion of the Armed Forces than the selected wartime periods. Veterans who served during one of the selected wartime periods and during another period are classified in the wartime period.

Veteran status is obtained from responses to the question, "Did you ever serve on active duty in the U.S. Armed Forces?"

Period of service is obtained from answers to the question asked of veterans, "When did you serve on active duty in the U.S. Armed Forces?" The following service periods are identified:

- Gulf War era II — September 2001-present
- Gulf War era I — August 1990-August 2001
- Vietnam era — August 1964-April 1975
- Korean War — July 1950-January 1955
- World War II — December 1941-December 1946
- Other service periods — All other time periods

Period-of-service definitions are modified occasionally to reflect changes in law, regulations, and program needs of the survey sponsors.

Veterans who served in Iraq, Afghanistan, or both are individuals who served in Iraq at any time since March 2003, in Afghanistan at any time since October 2001, or in both locations. Service in Iraq or Afghanistan is determined by answers to two questions, "Did you serve in Iraq, off the coast of Iraq, or did you fly missions over Iraq at anytime since March 2003?" and "Did you serve in Afghanistan, or did you fly missions over Afghanistan, at anytime since October 2001?"

Presence of service-connected disability is determined by answers to the question, "Has the Department of Veterans Affairs (VA) or Department of Defense (DoD) determined that you have a service-connected disability, that is, a health condition or impairment caused or made worse by any of your military service?"

Service-connected disability rating is based on answers to the question, "What is your current service-connected disability rating?" Answers can range from 0 to 100 percent, in increments of 10 percentage points. Ratings are determined by the VA or DoD from a rating schedule published in the Code of Federal Regulations, Title 38, "Pensions, Bonuses, and Veterans' Relief," Part 4—"Schedule for Rating Disabilities." The rating schedule is "primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations." Part 4 contains a listing of hundreds of possible disorders and assigns ratings of 0 through 100 percent, with instructions for rating multiple disorders.

Reserve or National Guard status is obtained from answers to two questions. Gulf War-era veterans were asked: "Was any of your active service the result of a call-up from the Reserve or National Guard?" If the answer was no, they were asked, "Have you ever been a member of the Reserve or National Guard?" A 'yes' response to either question classified persons as "Current or past member of the Reserve or National Guard." A 'no' response to the latter
question classified persons as "Never a member of the Reserve or National Guard." These questions were asked only of Gulf War-era veterans.

Reliability of the estimates

Statistics based on the CPS are subject to both sampling and nonsampling error. When a sample, rather than the entire population, is surveyed, there is a chance that the sample estimates will differ from the "true" population values they represent. The exact difference, or sampling error, varies depending on the particular sample selected, and this variability is measured by the standard error of the estimate. There is about a 90-percent chance, or level of confidence, that an estimate based on a sample will differ by no more than 1.6 standard errors from the "true" population value because of sampling error. BLS analyses are generally conducted at the 90-percent level of confidence.

The CPS data also are affected by nonsampling error. Nonsampling error can occur for many reasons, including the failure to sample a segment of the population, the inability to obtain information for all respondents in the sample, the inability or unwillingness of respondents to provide correct information, and errors made in the collection or processing of the data.

For a full discussion of the reliability of data from the CPS and information on estimating standard errors, see the explanatory note for the household survey available online at www.bls.gov/cps/eetech_methods.pdf.
Accommodating Student Veterans with Traumatic Brain Injury and Post-traumatic Stress Disorder: Tips for Campus Faculty and Staff

This report is the result of discussions during the Veterans Success Jam, held in May 2010. ACE is grateful to the Kresge Foundation for its generous support of the Jam. Special thanks to the Association on Higher Education and Disability (AHEAD) and America’s Heroes at Work for their help in the preparation of this report.

The Big Picture

Service members and veterans transitioning from deployment to higher education bring with them a degree of maturity, experience with leadership, familiarity with diversity, and a mission-focused orientation that exceed those of nearly all of their peers (Dalton, 2010; DiRamio, Ackerman, & Mitchell, 2008). They may be expected to emerge as campus leaders; to enrich any class focused on history, politics, or public policy; and to serve as an engine for innovation on their campuses (Branker, 2009). However, many veterans acquired these assets at great personal expense, including battlefield injuries (Barnhart, 2011).

Cognitive injuries are among the most prevalent of these battlefield injuries for today’s returning service members (Kato, 2010; Shea, 2010). By some estimates, individuals who serve in Iraq and Afghanistan have as much as a 40 percent chance of acquiring such an injury by the time they have completed their service (Kato, 2010; Milliken, Auchterlonie, & Hoge, 2007; Tanielian, 2008; Radford, 2009; Shea, 2010). Predominant among these cognitive injuries are traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). Consequently, to allow and encourage this transitioning population to realize the greatest gain from post-secondary education, campus faculty
and staff must recognize the potential learning challenges associated with these invisible injuries and make adjustments or implement accommodations to help ensure their students’ academic success (Church, 2009; Madaus, Miller, & Vance 2009).

To support faculty and staff who seek a better understanding of TBI and PTSD, this guide focuses on functional limitations commonly associated with these conditions and provides forms of classroom accommodations and modifications, also known as academic adjustments, responsive to these limitations. However, this information should not be divorced from the bigger picture, that individuals with combat-related TBI and PTSD will see themselves not as individuals with disabilities, but as veterans and service members (Church, 2009; Madaus, Miller & Vance, 2009). Campuses that are already well-prepared to serve veterans and service members in general will have far less need to specifically adapt to persons with cognitive impairments than campuses that have developed few veteran-specific programs or resources (Grossman, 2009).

### Traumatic Brain Injury and Post-traumatic Stress Disorder Defined

While TBI and PTSD are not veteran-specific injuries, the current conflicts overseas have pushed these two invisible injuries into the spotlight. Therefore, it is important to gain a basic understanding of each.

Traumatic brain injury (TBI) is defined as a blow or jolt to the head or a penetrating head injury that disrupts the functioning of the brain. A common cause of TBI is the ignition of an improvised explosive device (IED) that emits shrapnel, forcing the head of an individual suddenly against another object such as the roof of a jeep, or simply emits a barometric wave of energy. Even when the service member is not in direct contact with the device, an IED explosion may cause serious cerebral injuries. Conversely, not all blows or jolts to the head result in TBI. The severity of such an injury may range from very mild (a brief change

### Examples of veteran-centric programming:

- On-campus vets’ center or a one-stop veterans’ service center.
- A new student orientation program designed specifically for student veterans.
- A campus that is accessible to individuals with mobility impairments.
- An intramural program for persons with disabilities.
- Flexible enrollment and exit procedures.
- Credit for academic work accomplished while in the military.
- Close communication among disabled student administrators, counseling services, and veteran services officers.
- Drug abuse and suicide prevention programs.
- A campus-wide interdepartmental committee on veteran services.
- A president or chancellor who supports and welcomes veterans.
in mental status or consciousness), to severe (an extended period of unconsciousness or amnesia after the injury). TBI can result in short- or long-term problems, although most people with TBI are eventually able to function independently.

TBI is an umbrella term that spans a wide continuum of symptoms and severity. In fact, the large majority (80 percent) of combat head injuries sustained in Operation Iraqi Freedom and Operation Enduring Freedom are mild concussions as opposed to severe, debilitating TBI. For people with brain injuries, the most rapid recovery occurs in the first six months after the injury, and in milder cases, patients will often be back to normal within three months.

Post-traumatic stress disorder (PTSD) is a psychological health injury that can develop in response to exposure to an extreme traumatic event. These traumatic events may include military combat, violent personal assaults (e.g., rape, mugging, robbery), terrorist attacks, natural or man-made disasters, or serious accidents. The trauma can be directly experienced or witnessed in another person, and involves actual or threatened death, serious injury, or threat to one’s physical integrity. The person’s response to the event is one of intense fear or helplessness, and manifests itself with substantial hormonal and chemical changes in the brain. For some individuals, these hormonal and chemical changes abate promptly; for others, they persist.

Some people living with PTSD repeatedly re-experience their ordeal in the form of flashback episodes, intrusive recollections of the event, and nightmares. A stress reaction may be provoked when individuals are exposed to events or situations that remind them of the traumatic event. Avoidance of those triggering cues is a very significant feature of PTSD.

PTSD symptoms usually emerge within a few months of the traumatic event; however, symptoms may appear many months or even years later. Because it is normal for most people to experience some symptoms following a traumatic event, PTSD diagnoses are based on the intensity and duration of these symptoms. PTSD is treatable—and for many, symptoms will resolve completely, while for others, symptoms may

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Some of the cognitive difficulties associated with TBI and PTSD, which may affect academic performance, include:

- Attention and concentration difficulty.
- Information processing challenges.
- Learning and memory deficits.
- Sluggish abstract reasoning.
- Slowed executive functions (problem solving, planning, insight/awareness, sequencing).

Other challenges often associated with difficulty in classroom performance may include the effect of additional stressors (home, work, unit, etc.), sleep disturbance, difficulty with time management, and panic attacks.
persist for many years. In recent studies, service dogs have been found to be beneficial in helping alleviate many of the worst effects of PTSD in veterans.

Adjusting and Accommodating on Campus

For all that colleges and universities have already learned about accommodating individuals with TBI and PTSD, a confounding reality must also be recognized—few medical conditions express themselves as individually and uniquely as TBI and PTSD. The brain consists of many localized functions. Consequently, each injury may affect different sets of functions and similarly, no two traumatic events are the same (Smith-Osborne, 2009). One veteran may experience “survivors guilt” (Caplan, 2004) while another may have a learned perception that any abandoned vehicle is likely to contain explosives (Global Security, 2004).

Moreover, stressors may exist that exacerbate symptoms at certain times, but not at others. Both TBI and PTSD are commonly associated with depression and suicidal ideation (Huang, 2010). Other factors that may worsen symptoms include: academic stressors, health concerns and interpersonal issues such as dissolution of personal and marital relationships, sleep deprivation, alcohol and drug abuse, notice of redeployment, separation from battlefield and unit colleagues, and death of such a colleague (Kato, 2010). Institutions must recognize that many student veterans are facing other life-adjustments, as well as entry into higher education, such as reintegration into the social and family lives they held before their active-duty assignments (Knox et al., 2010). However, other factors may have a restorative effect, such as social support particularly by other veterans and service members, professional treatment, balanced participation in recreational or pleasurable activities, and good health habits (Larsen, Highfill, & Booth, 2008).

Not all student veterans with TBI or PTSD will require adjustments or accommodations to succeed in a college atmosphere, and others may require only a few modifications to the learning environment (Shea, 2010; Smith-Osborne, 2006). Though such determinations are made on a case-by-case basis, many, likely most, veterans and service members with TBI or PTSD qualify as an “individual with a disability” under two federal disability antidiscrimination laws applicable to colleges and universities: the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973 (Grossman, 2009; Shackelford, 2009). As a civil right, these individuals are entitled to attend a campus with programs and facilities accessible to individuals with disabilities as well as a wide range of academic adjustments and auxiliary aids (accommodations), as long as such accommodations do not fundamentally alter the academic program in question (Grossman, 2009; Shackelford, 2009). The U.S. Department of Education Office for Civil Rights and the Civil Rights Division of the U.S. Department of Justice enforce these rights.

Unfortunately, veterans and service members with disabilities are less likely than most students to access the accommodations they are entitled to for a host of reasons, reducing their chance of persisting to graduation and placing a burden on faculty to address problems on an ad hoc basis (Madaus, 2009).
Institutions, faculty, and staff need to be affirmative and outspoken in making sure that veterans and service members with disabilities are aware of their rights under these two laws and understand the legitimacy of claiming those rights (Madaus, Miller, & Vance, 2009; Shackelford, 2009; Burnett & Segoria, 2009). Stovepipe bureaucratic thinking among the various entities responsible for individuals with disabilities and individuals responsible for veterans and service members must be discouraged and remedied (Grossman, 2009; Burnett & Segoria, 2009).

It is also important to understand the perspective of veterans with disabilities as much as possible, given that the majority of Americans have never been in their situation—and for combat veterans, the physical and mental impact of combat cannot be understood by those who have not been in that situation. Veterans’ struggles while returning to civilian and school life are very complex (Honolulu Community College,

To best assist student veterans in integrating into on-campus life, it is imperative that the postsecondary community keeps in mind the following points:

- In most instances, veterans are new to their disabilities, without prior history or knowledge of individuals with Disabilities Education Act (IDEA)/Section 504 eligibility. Additionally, most will be unaware of their rights as students with disabilities or how to go about receiving academic accommodations (Madaus, 2009).
- Veterans with newly acquired injuries (both seen and unseen) are just developing an understanding of how their disability may affect their learning. For example, an individual may have acquired a learning disability as a result of a TBI and had no previous history of a learning disability prior to the injury. Attending school is a huge adjustment in itself; realizing that learning has become a challenge in ways it never was before will be an even bigger adjustment (Burnett & Segoria, 2009; Church, 2009; Grossman, 2009; Madaus, 2009; Madaus, Miller, & Vance, 2009; Vance & Miller, 2009).
- The psychological process for accepting disability status will take time, especially for those with a military background. At first, veterans may view their disability—and asking for help—as a sign of weakness.
- Many student veterans are facing other adjustments beyond that of initial entry into post-secondary education, such as reintegration into the social and family lives they held before their active duty assignments.
- Veterans are not usually the typical college student. Many are older and, according to the National Council on Disability, 60 percent of those deployed are married and over half have children. TBI and PTSD can significantly impact an individual’s personality and ability to cope with day-to-day activities, which puts a tremendous strain on marriage and family life.
- Common disabilities of veterans of the wars in Iraq and Afghanistan include: TBI, PTSD, loss of limbs(s), severe burns, deafness, vision difficulties, and learning disabilities.
Understanding the fine distinctions between military and VA disability designations may be an added burden, as would be understanding the nuances of the ADA and Section 504 (Madaus, 2009). Additionally, a true diagnosis of PTSD, and in some cases a mild TBI, can occur after the service member has separated from military service. This means a veteran may be discharged from the military without realizing that she or he may experience a significant learning or memory-related impairment (Church 2009; Yonkman & Bridgeland, 2009).

Creating a Positive and Welcoming Learning Environment

Faculty and staff must get to know a representative from their campus’s Disability Services (DS) office. The professionals in the DS office are responsible for reviewing possible accommodation needs of students with disabilities, reviewing and storing medical documentation, and ensuring access to reasonable accommodations. Most institutions recognize that having only one office or individual responsible for the collection of disability documentation is a best practice. As a result, information regarding a student’s specific disability diagnosis is not considered a faculty “need to know.” Therefore, under this model, faculty only need to know what accommodations have been deemed to be appropriate by the DS office for any particular student.

In the event faculty recognize that a student exhibits signs of PTSD or TBI, they need to consider carefully when and how, if ever, they will bring the topic up with the student. If faculty take into consideration suggestions in this article for how to make their courses more universally accessible to all students, they may have done all that is needed.

On the other hand, should faculty recognize or suspect a student may benefit from accommodations due to a disability, they should arrange a private meeting with the student to express concern over the student’s academic performance, and suggest a referral to DS. It is important that faculty recognize that students cannot be forced to go to DS, nor can they be forced to accept accommodations.

Students believing they may benefit from accommodations, or interested in learning more about the accommodation process, should arrange to meet with a DS staff member. The staff member will then spend some time getting to know the student, review any medical documentation, and then develop an accommodation plan. Included in this intake meeting is a form or process for notifying faculty of required academic accommodations. Once faculty have been notified of any academic accommodation needs for the student, the faculty are obligated to provide reasonable accommodations.

Under this model, Disability Services professionals make the specific decisions related to whether a student is qualified to have a reduced course load, service animals (to help with PTSD stress reduction), access to specialized software, or other accommodations that go beyond the scope of what faculty can reasonably provide to all their students. If there is no centralized person or office charged with overseeing the student accommodation process, faculty and staff need to learn the accommodation process unique to their campus.

Faculty and staff also should become familiar with other campus
or community resources charged with working with student veterans, such as the campus veteran certifying official (generally housed in the Office of the Registrar), campus student veteran center, and other community contacts if available. This information will assist them in providing appropriate referrals.

Understandably, online courses are very popular for veterans who may be transitioning into the world of post-secondary education or are unable or unwilling to sit in a regular classroom. Faculty who teach online courses should review their syllabi and course requirements to check for flexibility related to homework assignment deadlines, timed exams, and general content accessibility. It is highly recommended that online faculty work with technology staff to guarantee universal access to course content. Working with DS staff can help ensure courses more appropriately include academic adjustments that accommodate veterans as well as other students with various disabilities, without compromising the academic integrity of the courses.

Faculty also may consider including a statement on every course syllabus inviting students with disabilities to meet with them in a confidential environment to review course requirements and discuss academic adjustments or reasonable accommodations. For example:

Students with disabilities are encouraged to contact me to privately discuss any accommodation needs. The University of (X) ensures equal access to instruction through collaboration between students with disabilities, instructors, and Disability Services for Students (DSS). “Reasonable” means the University permits no fundamental alterations of academic standards or retroactive modifications. For more information, please consult (web site). Should you have a disability, including unseen disabilities such as learning disabilities, psychological health injuries (such as PTSD), or cognitive disabilities (such as brain injuries), that requires reasonable accommodations, please contact the Office of Disability Services.

Again, it is important to remember that faculty should not be involved with the handling of the student’s medical documentation or diagnosis, as this is generally the responsibility of the DS office. However, faculty can certainly take steps to benefit all students, including students with TBI and PTSD. For example, providing all students with online class notes, using assessment criteria other than timed exams, and remaining flexible in terms of classroom participation are all things faculty could provide to all students without regard to documented disability, but that would particularly benefit veterans. As faculty more often use universal strategies to benefit all their students, those students who are reluctant to identify as having a disability will be less academically at risk.

Finally, when meeting with a student veteran who may be experiencing academic performance concerns, it may be useful to consider a few questions. Has the student discussed the need for possible accommodations? If so, it would be useful to meet with the student privately to evaluate the effectiveness of the accommodations in the classroom setting. If further accommodations are required, particularly efforts that go beyond the scope of what one would normally provide for any other student,
then the student veteran may need to be referred to Disability Services for additional accommodations. The other question to consider would be whether the student has connected with the local VA, DVA, or other military department able to provide TBI or PTSD support for veterans. If not, faculty could provide the contact information.

### Improving the Teaching/Learning Environment

With advanced planning, faculty can ensure that all students (student veterans, non-native English speakers, nontraditional students, and students unwilling to self-identify or self-advocate) have access to a range of academic adjustments.

Advanced planning to incorporate universal design for learning (UD) into the curriculum makes good teaching

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### Concentration/Memory Tips

- Permit in-class use of laptop computers for note taking.
- Be willing to wear FM microphones or be open to use of any other improved listening technology.
- Provide handouts in a timely manner so that those needing to convert documents to an electronic format have time to do so.
- Ensure that required texts are available in an accessible electronic format.
- Plan ahead to ensure all audio clips, videos, and movies are captioned, as many veterans have experienced hearing loss. They can also benefit from captioning to keep them on track.
- Utilize electronic platforms to store lecture notes, so that students may access the information through alternative electronic formats, as needed.
- Permit the in-class use of tape recorders or other audio recording devices as memory aids.

### Test-taking Tips

- Eliminate timed tests in favor of other assessment methods that do not penalize students who require extra time, low-distraction testing accommodations, or attendance flexibility, regardless of whether a disability has been identified.
- Administer tests on the computer.
- Allow students to be able to use an index card with faculty-approved notes or build memory joggers into the exams (if exams are necessary).
- Allow students to use index cards, blank paper, or a ruler to help keep their place on exams.

### Tips for Alleviating Panic Attacks/Stress

- Allow students the ability to take a short break (5–10 minutes) during class sessions or testing environments when stressful situations arise.
- Permit flexibility in class session attendance schedules, as long as absences do not conflict with the core requirements of the class.
sense. Furthermore, usage of UD recognizes that building flexibility into the course syllabus and course expectations up front may mean more effective learning opportunities for all students. In the long run, using UD may also lessen stress for students who require accommodations, but don’t necessarily identify such a need until the semester is underway. Preparing for flexibility ultimately can lead to improved retention and student success.

The box below lists some possible ways, not at all comprehensive, that faculty can build a curriculum to improve the learning opportunities for all students, especially those with PTSD and TBI. None of the academic adjustments identified here should lead to reduced academic performance expectations, nor do they necessarily require Disability Services authorization if made available to all students and planned well in advance.

What Else Can Be Done?
No matter what political views faculty and staff members have, they should honor a student veteran’s service and respect the student’s privacy. Faculty must recognize that student veterans provide a unique opportunity that may (positively) challenge how they teach and assess. This recognition of the need to provide more flexible ways to teach and assess student learning benefits not only student veterans, but also any other students who may appreciate having the same flexibility extended to them. In doing so, institutions may experience improved retention and graduation rates. And, more importantly, faculty and staff will have helped the student veterans achieve their mission to earn a degree.
References


Church, T. E. (2009). Returning veterans on campus with war related injuries and the long road back home. *Journal of Postsecondary Education and Disability*, (22)1, 43–52.


From Soldier to Student:
Easing the Transition of Service Members on Campus

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Executive Summary

The United States is poised to welcome more than 2 million veterans as they return from Iraq and Afghanistan. These veterans will be the beneficiaries of a new GI Bill that will remove most financial barriers to attending college. Because of the generous education benefits offered by the Post-9/11 GI Bill, many of these veterans—as well as those still serving in the active, reserve, and National Guard components of the armed forces—will enroll in higher education to enhance their job prospects, achieve career goals, expand their knowledge and skill sets for both personal and career enrichment, and facilitate their transition to civilian life.

How well prepared is higher education to serve these new students? Despite the long history of veterans’ education benefits and presence of veteran students on campus, little research has been conducted about campus programs and services that aid veterans in their college transition. This report represents the first attempt to assess the current state of programs and services for veterans on campuses across the nation, based on survey results from 723 institutions. It will help campus leaders understand “the state of the art” among the most veteran-friendly campuses, recognize factors that appear to influence the level of service campuses provide, and identify gaps in their own offerings.

All Responding Institutions
- More than half of all responding institutions (57 percent) currently provide programs and services specifically designed for service members and veterans, and roughly 60 percent of all responding colleges and universities indicated that providing programs and services for military service members and veterans is a part of their long-term strategic plan. More than half of all responding colleges and universities reported engaging in recruiting efforts specifically designed to attract military service members and veterans.
- Public four-year (74 percent) and public two-year (66 percent) institutions are more likely to have programs specifically designed for military veterans than private not-for-profit colleges and universities (36 percent).
- Most responding campuses are considering veteran-friendly changes to their institutions in the next five years, the top two of which are providing professional development for faculty and staff on dealing with the issues facing many service members and veterans, and exploring state or federal funding sources or submitting grant proposals to fund campus programs. Survey results bolster the need to focus on professional development, as fewer than half of all schools with military/veterans programs offer opportunities for faculty and administrators to acquire infor-
mation about the unique needs of military student populations, existing campus resources, and promising practices to create a positive campus environment.

**Institutions that Provide Services for Veterans and Military Personnel**

- The survey found great diversity in how institutions serve veterans, the variety of services and programs offered, and where services/programs are housed within the administrative infrastructure.
- Sixty-five percent of colleges and universities that offer services to veterans and military personnel have increased their emphasis on these services since September 11, 2001, including 70 percent of four-year public institutions, 65 percent of public community colleges, and 57 percent of private not-for-profit four-year colleges and universities. The top two areas of emphasis, regardless of sector, have been the establishment of new programs and services for service members and veterans, and the establishment of marketing and outreach strategies to attract veterans and military personnel.
- Many institutions provide financial assistance in the form of discounts or scholarships specifically for veterans. The most common forms of financial assistance at public colleges and universities include eligibility for in-state tuition rates for both veterans and their family members. At private institutions, discounted tuition rates for both veterans and family members were the most frequently cited type of financial assistance.
- Nearly 80 percent of all colleges have an established policy regarding tuition refunds for military activations and deployments. Higher education as a whole has not responded as consistently in terms of re-enrollment policies and procedures when students who are called up to military service return to campus. Only 22 percent of institutions with programs and services for military personnel have developed an expedited re-enrollment process to help students restart their academic efforts; most (62 percent) require students who are returning from deployment to complete the standard re-enrollment process, and 16 percent require students to reapply and be readmitted in order to enroll.
- Almost all campuses that have services for veterans and service members offer some type of academic support or student service designed specifically for these students. Aside from Department of Veterans Administration (VA) education benefits counseling, the most frequently cited services were financial aid counseling (57 percent), employment assistance (49 percent), and academic advising (48 percent).
- More than 70 percent of public four-year institutions and more than 40 percent of private not-for-profit four-year and public two-year institutions that offer services for veterans and military personnel have counseling centers to assist these students with issues such as post-traumatic stress disorder or depression. Significantly fewer institutions have established programs or services specifically designed to assist veterans with physical disabilities and less visible disabilities such as brain injuries; only 33 percent and 23 percent of institutions reported having staff...
trained to assist veterans with these two conditions, respectively.

- Almost three-fourths of all reporting colleges and universities with programs and services for veterans and military personnel award credit for military training and occupational experience.

- In focus groups and meetings, student veterans have expressed the need to connect with those who share similar experiences. Although student veterans perceive veteran clubs/organizations and vet-to-vet counseling as high priorities for aiding veterans in collegiate transitions, only 32 percent of institutions with services for veterans and military personnel have clubs or other organizations for these students. Establishing student veteran clubs and providing informal gathering places for student veterans to connect with one another may contribute significantly to their acculturation on campus.

Programs and Services by Level of Veteran/Military Enrollment

- Generally, colleges and universities that have larger service member and veteran populations are more likely to offer programs and services for these students than institutions with smaller military/veteran populations. However, the “tipping point” appears to be quite low; 62 percent of institutions where veterans represent just 1 to 3 percent of enrollment offer special services for this population. Services that appear to be especially sensitive to the size of the student veteran population are training staff specifically to work with veterans, establishing an office dedicated to working with veterans, and creating targeted recruitment of military personnel and veterans.

- This study also revealed that postsecondary institutions that have smaller veteran and active-duty military populations are increasing their emphasis on serving these students, particularly since September 11, 2001. Much of the increased emphasis has been on new programs for veterans including counseling services, the appointment of committees to develop action plans to respond to veteran needs, and increasing marketing and outreach to veterans.

Programs and Services by Administrative Structure

- The presence of a dedicated office for veterans and military students is an indication of institutional commitment; 49 percent of institutions that offer programs and services for veterans and military personnel have such an office.

- Among colleges and universities that have a dedicated office that provides support for military students, 75 percent of institutions have increased their emphasis on services and programs specifically for service members and/or veterans since September 11, 2001. Fifty-six percent of institutions that do not have a dedicated office have increased their emphasis on veterans and military personnel since September 11.

- In general, institutions with a dedicated office were more likely to make programmatic changes after September 11, 2001, than institutions without a dedicated office. These changes included establishing new programs and services (71 percent of institutions with a dedicated office versus 52 percent of institutions
without such an office); establishing marketing and outreach strategies to attract veterans and military student populations (62 percent versus 51 percent); increasing staff in existing programs and services for service members/veterans (42 percent versus 21 percent); and increasing counseling services and/or off-campus referral procedures to address their needs (59 percent versus 42 percent). Institutions with a dedicated office also were more likely than those without such an office to engage in recruitment efforts targeted to service members and veterans (61 percent versus 42 percent) and to offer training for faculty and staff regarding the transitional needs of these students (49 percent versus 36 percent).

Institutions that have a dedicated office for veterans and military personnel are much more likely to tailor common services to these students, including financial aid/tuition assistance counseling, employment assistance, academic advising, campus events, and career services. Likewise, institutions with a dedicated office are much more likely to sponsor a student organization for veterans and military personnel (41 percent versus 23 percent).

Campuses with a dedicated office are more likely than others to offer specialized counseling and support groups, and to refer students to support services offered by the VA, but still appear to underuse peer support groups.

With regard to administrative policies on such matters as financial aid or awarding of credit, there were fewer differences between institutions that do and do not operate an office dedicated to military personnel and veterans. This may be because these broad academic policies are outside the purview of an office of military/veterans services. However, institutions with a dedicated office for veterans and military personnel are much more likely than others to offer special tuition rates.

**Focus Group Results**

- The statistics in this publication provide a national measure of institutional efforts to serve military service members and veterans. To examine whether a disconnect exists between veteran needs and campus programs/services, ACE conducted focus groups in July 2008 with both veterans and enlisted service members to gain insight into their perceptions of postsecondary education.
- Veterans and service members in the focus groups mentioned several areas of concern about currently available campus services and programs, including a lack of flexibility of some campus programs with respect to military students’ sometimes unpredictable deployment schedule in the armed forces; uncertainty about campus recognition of civilian courses taken while in the military and/or formal training obtained as a service member; and lack of strong guidance about navigating the maze of GI Bill education benefits.
- The frequency with which some of the focus groups’ concerns surfaced suggests that college and university campuses could do more to improve their support services and programs for veterans and service members, and to publicize the services they already have in place.
The Post-9/11 GI Bill is expected to increase the participation of military service members and veterans in postsecondary education. This report set out to identify the types of programs and services that exist on college campuses for military students in order to learn more about higher education’s readiness to serve a greater number of these students. The findings from this report reveal many things that higher education is doing well in addition to several areas for improvement.

Among the areas where higher education is meeting the needs of military students:

- Acknowledging the importance of serving military service members and veterans in strategic plans. Nearly 60 percent of institutions have service for military students in their long-term strategic plans.
- Offering programs and services for veterans. More than 55 percent of campuses have programs that are specifically designed for military veterans. Sixty-five percent of colleges and universities have increased their emphasis on military students since September 11, 2001.
- Recognizing prior military experience. Eighty-one and 64 percent of institutions with services for military personnel and veterans award college credit for military training and military occupational training, respectively.
- Assisting military students with finding appropriate counseling services. Eighty-five percent of campus counseling centers at institutions with services for military students coordinate and refer students to off-campus services when necessary.
- Providing financial accommodations for military students who are called to active duty. Seventy-nine percent of colleges and universities with military services have an established policy for refunding tuition for military activations and deployments.
- Assisting military veterans with their education benefits. Eighty-two percent of postsecondary institutions provide VA education benefits counseling for military students.

The areas in which higher education can improve in serving military students:

- Assisting military students with their transition to the college environment. Only 22 percent of postsecondary institutions with services for military students and veterans provide transition assistance.
• Providing professional development for faculty and staff on the transitional needs of military students. Approximately two out of five schools that service military students and veterans provide training opportunities for faculty and staff to be better able to assist these students with their transitional issues.

• Training staff to meet the needs of military students with brain injuries and other disabilities. Twenty-three and 33 percent of colleges and universities that service military students and veterans have staff who are trained to assist veterans with brain injuries and other physical disabilities, respectively.

• Streamlining campus administrative procedures for veterans returning from military deployments. Only 22 percent of institutions with programs and services for military personnel have developed an expedited re-enrollment process to help students restart their academic efforts.

• Providing opportunities for veterans to connect with their peers. Only 32 percent of institutions with services for veterans and military personnel have a club or other organization for these students.

The presence of staff with some level of training in meeting the needs of military students as well as basic familiarity with the military can be a critical factor in the success of military service members and veterans. As a veteran participant in the ACE “Serving Those Who Serve” summit commented in relation to this issue, “In order to help students, you need to help the faculty and administration.” At campuses in close proximity to military bases, all faculty and staff—not only the veterans’ affairs office staff—may have more opportunities to learn about the needs of military personnel and veterans. At campuses not located near a base, more effort may be needed to educate members of the campus community on how to best help veterans acclimate to the campus environment. Some campuses have created special staff positions or departments to serve the needs of veterans, as demonstrated in this report. These offices appear to raise the overall level of activity on behalf of service members and veterans, but it is also important that their presence not deter a campus from making sure that all faculty and staff are sensitive to the needs of this population.

Although just more than half of campuses have programs specifically for veterans, there are many key administrative and student support areas in which very few campuses provide services specifically for these students, such as academic advising/tutoring, career planning, or campus social events. However, services are offered most often to all students through central academic affairs offices or within a particular college at a large university, rather than divided out by veteran/civilian student status. Additionally, according to a veteran participant in ACE’s “Serving Those Who Serve” summit:

“What veteran-friendly colleges don’t do is coddle veterans. Instead, they create environments in which vets have the tools to engage in debate and make use of resources.”

—Army combat veteran and Georgetown University student
Veterans are not necessarily looking to be isolated or have special programs created on their behalf. More than anything, they are looking for an educational environment that provides the tools and resources that allow them to succeed.

This report provides a first look at the kinds of environments that institutions are providing for military students. As the Post-9/11 GI Bill is implemented, and the number of veterans who served in Iraq and Afghanistan increases, it will be important for institutions to revisit their level of service. This survey provides a benchmark for institutions to measure their progress to date; institutions and organizations alike may wish to use the data as part of their own ongoing efforts to evaluate and improve the types of services they provide to active-duty and veteran students. Further research will be necessary to ensure that our service members and veterans are receiving no less than the best efforts they deserve from higher education.
Commentary from Nancy K. Schlossberg

Student Veterans and Transition

Nancy K. Schlossberg spent most of her career as a professor of counseling psychology. She taught at Howard University, Wayne State University, and twenty-six years at the University of Maryland, College Park, and served as president of the National Career Development Association. Schlossberg is the author of nine books. She is copresident of TransitionWorks, a consulting firm, and professor emerita at the College of Education, University of Maryland, College Park.

Dr. Schlossberg: Veterans deal with multiple transitions. They are leaving the military, along with their colleagues. Even though there is relief, even excitement about returning home, they are leaving the familiar, their friends, and sense of mission. At the same time that they are dealing with “role exit” matters, they are moving into two new systems: reintegrating with their families and starting college. We love to picture the male or female soldier coming home to a warm, loving family and getting back right into the groove, but that’s not reality. We are really discussing a series of complex and complicated transitions.

Student services and counseling services are key to establishing transition programs that could make a difference. It would be useful to identify and visit model programs in the country for clues that could be modified for local programming. The following suggestions might serve as a starting point:

Step 1. Set up a one-to-one support system so that every veteran has an individual with whom to explore expectations and feelings. Establishing these “socializing agents” can be the cornerstones of a successful transition. The first consideration is to understand the challenge of moving into any new system, which requires “learning the ropes.” There is a great deal of confusion about any new system. Certainly, going to college for the first time is an enormous challenge, especially for veterans, many of whom are unable to clear their minds so that they can focus on the textbook they’re supposed to be reading or the paper they’re supposed to be writing.

Step 2. Establish a group situation with weekly meetings. I wrote (1981; Goodman, Schlossberg, and Anderson 2006) about the work of Robert Weiss (1975, 1976) and how he dealt with helping people in transition after a divorce. Of course, that’s a different transition, but his model can be adapted for veterans. Whenever I’ve set up a transition program for populations new to me, I conduct focus groups as a way to ensure that the participants define their major concerns. Nobody else can walk in their shoes, but it is important to listen and be responsive to their voices.

The group meetings would pair the new veterans coming to college with veterans who have successfully negotiated the transition. An experienced group leader could steer the discussion so that it dealt with an underlying issue: the confusion, the ambivalence, the thoughts that you can’t control, etc. Many of these veterans felt that they were doing something important, that they mattered to their country, and performed beyond what most people can do. Now, they have come to college and are often treated like children. There are many things that potentially could make them feel put down. Here they are, men and women, strong in the military and now they are children in the classroom.

Step 3. Establish group meetings with veterans’ significant others. The veterans are trying to balance school and family. Often family members might not understand what is going on, and they too need to share their feelings. For example, assume a soldier is in a family with two or three children and that that returning veteran is expected to help at home; meanwhile, he or she has a paper due. It’s about balancing; it’s the same old, same old-balancing work, family, and school.

This topic is very important. If we can ease the way through intentional student service programs, we too would be making a contribution to our country. It takes a lot of guts to start school, but education will be their stepping stone to a better life.
Veterans Struggle To Fit Into College Campuses (transcript)
by KAREN BROWN

October 10, 2009

The transition from combat to college is not always seamless. Some war veterans simply can't relate to typical freshmen behavior and others have trauma-related symptoms. With more than 100,000 U.S. veterans of the wars in Iraq and Afghanistan expected to enter college this year under the new G.I. Bill, veteran advocates are wondering whether enough services are in place to help them adjust.
Karen Brown of member station WFCR reports.

SCOTT SIMON, host:

The number of veterans on U.S. campuses is expected to jump by 30 percent this year, thanks to the federal G.I. Bill. That could mean 100,000 veterans across the country, according to some estimates. But even with financial help, the transition from combat to campus can be difficult.

Karen Brown of member station WFCR reports.

KAREN BROWN: When John Schnaber(ph) finished his combat duty in Afghanistan, he was eager to get a college degree and enrolled at the University of Massachusetts. He got mostly A's but just couldn't relate to his fellow students. He'd survived shelling, shooting and worse, while most of his classmates were fresh high school graduates just out of their parents' homes.

Mr. JOHN SCHNABER: People were running up and down the halls at night, screaming yelling at night, just general freshman college kind of behavior. It brings up issues.

BROWN: Schnaber is now a veteran's advocate at the UMass Amherst campus. And those issues he mentioned start with memories of combat.

Sociology major John Goldman still cowers from rocket-propelled grenades whenever he hears a high-pitched whistle. He says others have it worse.

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Mr. JOHN SCHNABER: People were running up and down the halls at night, screaming yelling at night, just general freshman college kind of behavior. It brings up issues.

Sociology major John Goldman still cowers from rocket-propelled grenades whenever he hears a high-pitched whistle. He says others have it worse.

Mr. JOHN GOLDMAN: There are some guys who need to sit in the back corner of the room during class, so no one is going to surprise them, no one is going to come up behind. They're just sizing things up. Every situation they're saying, Where's my exit? Who looks shady? Who, you know, just - they're still in the combat mindset.

BROWN: Even if the problems aren't that disruptive, veterans may feel isolated, like they don't fit in. History major and veteran Eric Fioli(ph) remembers scoffing at fraternity pledge week, thinking the Greek experience had nothing on the close bonds of military life.

Mr. ERIC FIOLI: That's camaraderie. That's brotherhood. What's their idea of brotherhood? Coming back in 15 years and reliving the fraternity college experience, undergrad experience? Come on.

BROWN: Granted, veterans often have a tough re-entry into civilian life, but the surge in veterans entering college has renewed debate on how a university should or can do to help.
Jack Mordente of Southeastern Connecticut University says the typical 18-year-old freshman gets much more hand-holding.

Mr. JACK MORDENTE (Director, Veterans Affairs, Southeastern Connecticut University): The University reaches out to the true freshmen and brings them in for orientation. You know, the veterans don't get that. As an older adult student, you know, they're coming here pretty much on their own.

BROWN: Mordente, himself a counselor and Vietnam vet, is with the National Organization of Veteran Program Administrators, which advocates for campus services. He says almost every major campus is seeing an influx of veterans and most administrators are anxious about it.

Mr. MORDENTE: The universities, you know, you get two, three hundred vets going to school and, you know, that's a significant amount. And you are taking on the responsibility, I think, or burden of a population that some of them can have some real issues.

BROWN: Including cases of Post Traumatic Stress Disorder, anxiety, depression, alcohol abuse, and other adjustment problems. While student vets can get therapy at a Veterans Affairs medical center, Mordente says few make use of that resource. And that leaves university staff to fill in the gaps.

Federal funding for veteran support on campus dried up in the 1980s. Mordente's group is lobbying to bring it back. But until then, it's up to each school to decide what it needs and can afford.

Ms. JUDY GAGNON (Director, Military Community Resource Center): It does feel overwhelming. We have been preparing for, you know, an onslaught.

BROWN: Judy Gagnon runs a military resource center at UMass, which serves an estimated 400 veterans, about twice as many as last year. Her job is to guide vets through the university bureaucracy and to help them feel welcome on a traditionally liberal campus that tends not to embrace military culture.

Ms. GAGNON: (unintelligible) surprise to see you this afternoon.

Unidentified Man: Oh, you'll be seeing more of me up there.

Ms. GAGNON: Okay.

BROWN: This drop-in center is considered a model for other schools. But Gagnon says she still worries about veterans falling through the cracks, especially when it comes to mental health care. Like most colleges, UMass hasn't hired additional counselors to handle veteran issues. But it has held staff trainings on military culture and PTSD.

And veterans who've been on campus longer try to look out for the newer ones. They say just having a designated veterans' hangout, a place to talk with people who know your story, goes a long way.

For NPR News, I'm Karen Brown.

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Creating a veteran-friendly college as part of your brand

Commentary
By Joanne Truesdell and Janet Paulson, Published November 7, 2011

With the prolonged U.S. involvement in conflicts around the globe, a new generation of military veterans is returning home.

This is a different generation of veterans—they’re smart, they have skills and they have comprehensive educational benefits.

An estimated 2 million service members and their families are eligible for newly expanded benefits under the federal Post 9/11 Veterans Educational Assistance Act.

Community colleges are ideal to meet the needs of veterans. They are located in geographically dispersed areas that make education available and accessible, and they offer an introduction to the benefits of education, regardless of one’s goals. In addition, two-year college programs and staff are intrinsically committed to helping students overcome obstacles to success.

With the commitment to creating a veteran-friendly environment, community colleges can aptly serve this valuable population.

The new GI Bill
Signed in to law in 2008, the new GI Bill offers up to 100 percent tuition and fee assistance at institutions of higher learning, housing assistance, an annual stipend for books and school supplies, and the option to transfer benefits to immediate family members.

These new benefits have created a surge in the number of veterans, service members and their family members attending college. In Oregon, the number of veterans receiving educational benefits increased 89.5 percent (from 4,563 to 8,726) in the 26-month period from March 2009 to May 2011. This increased enrollment is driving the need for more support and student services for this population.

The majority of military undergraduates are between ages 24 and 39, increasingly diverse and female, and likely to be married. Balancing family life and transitioning from the structure of military service makes marketing the college experience focused on both the student and the entire family essential. Visibility is the first need military undergraduates have to find services. Clear community, Web and campus presence is central to beginning the transition to college.

Promising practices
In 2009, Clackamas Community College (CCC) in Oregon was one of 20 colleges and universities awarded an American Council on Education (ACE) Walmart Foundation Success for Veterans grant. CCC also received a federal grant to improve outreach to veterans in the region.

Through these efforts, combined with rich community partnerships, CCC has made veteran outreach and service a key college initiative. From this work and the work of other community colleges around the country, best practices have emerged to meet the needs of our military and veteran students. Some key lessons:

• Dedicate staff members who speak the “veteran language.” Navigating through complex educational benefits is challenging. Providing staff to assist veterans in determining which benefit to use is a core service. Veterans helping veterans is ideal.
• **Keep veterans services in one place.** Experts state that creating a unique space for veterans sends the message that your college is veteran friendly. The military culture is very different from that of higher education. Be sensitive to those differences.

• **Create strong partnerships.** In this time of extremely stretched college resources, connecting to community nonprofit, local, state and federal veterans’ service providers is essential. Internally, peer organizations or clubs create a way for military undergraduates to connect with others and provides leadership opportunities.

• **Serve the entire family.** Community support services for families, on-site child care, financial-aid advising and additional college or private foundation scholarships are valuable.

• **Educate your staff.** Provide resources through veteran panels or outside experts on working with veterans and military undergraduates. Make it a priority from the executive suite.

In 1947, the Truman’s Commission Higher Education for Democracy rightly identified community colleges as the educational entity best positioned to address the needs of veterans. Today more than ever, we are best prepared to serve those who serve our country.

*Truesdell is president of Clackamas Community College (CCC) in Oregon. Paulson is public information officer at CCC and director of District 7 of the National Council for Marketing and Public Relations.*
The number of women veterans attending college is increasing. Campus professionals need to be aware of how issues pertaining to mental health, sexual assault, and gender identity may influence how these women make transitions to higher education.

Meeting the Needs of Women Veterans

Margaret Baechtold, Danielle M. De Sawal

Just as veterans are an increasing segment of our student population, women are becoming a larger proportion of the veteran population. The demographics of the United States’ active-duty military force have shifted dramatically over the past twenty-five years, especially in regard to gender. In 1973, women made up only 2.5 percent of the total active-duty force, but by 2005, the number had increased fourfold, bringing the total to approximately 14 percent (U.S. Department of Veterans Affairs, 2007). In addition, the recent rise in the total number of female personnel serving on the front lines of two wars is placing women in new roles, both as members of the military and as veterans. Media reports indicate that approximately 11 percent of U.S. troops deployed to Iraq or Afghanistan are women, and a total of more than 182,000 have served there since these conflicts began. This is a historic increase in women who have been deployed to combat zones. In comparison, during the Vietnam conflict, roughly 7,500 women were deployed, primarily as nurses. Changes in assignment policies for women increased that number to 41,000 in a wide range of career fields during the Gulf War (Stone, 2008).

Not only have the numbers of women in the military increased, but their exposure to the stresses of war has increased as their location in combat zones has changed. Formally, the policy of the military is that women are to be excluded from assignment to combat arms units, but the lines between combat and noncombat missions in the current conflicts are frequently almost nonexistent (Baker, 2006). In modern combat operations, support units are as susceptible to attack as frontline units, with “no safe
place and no safe duty” (Litz, n.d., p. 1). In combat, “women are co-located with ground combat units. These women are providing convoy security; they are leading convoys in, to, and through ground combat as well as patrolling main supply routes” (Baker, 2006, p. 10). As a result, women are as exposed to the dangers of war as men and are subject to the same stresses and mental health concerns (Stone, 2008). The increase in the number of women enrolling in postsecondary education following their tour of duty suggests that campus professionals need to become aware of how issues associated with mental health, sexual assault, and gender identity may influence how women veterans make the transition into the higher education environment. This chapter addresses the special needs of women veterans.

**Mental Health Problems**

Mental health issues on college campuses have received increased attention over the past several years as a result of the shootings at Virginia Tech and Northeastern Illinois University. The mental health concerns associated with military service and combat are often understood by society through the personal stories that veterans share. This view could lead those not familiar with military-related health issues to conclude that these problems are common among veterans. The reality is that a moderate percentage of veterans are diagnosed with mental health issues, according to the National Center for Posttraumatic Stress Disorder (n.d.). However, student affairs administrators need to be aware that returning combat veterans need a safe place in order to process their war-related experiences.

**Post-Traumatic Stress Disorder.** The connection between post-traumatic stress disorder (PTSD) and military veterans has been acknowledged for many years. The estimated risk of suffering from PTSD is approximately 18 percent after service in Iraq and 11 percent after service in Afghanistan (Litz, n.d.). While the percentage of veterans who are expected to be diagnosed with PTSD is moderate, many others will have experiences that will require support to process. Student affairs personnel need to be prepared to assist veterans who come to campus with experiences that are not common in the traditional college student. Student veterans will likely require time and support in a nonthreatening environment to process their experiences, especially with peers who are veterans and who understand what it means to be deployed to a war zone. Advances in medical and military technology have made the survival rate in combat historically high. This fact creates a situation in which soldiers are much more likely to witness or suffer from the “aftermath of violence” (Litz, n.d., p. 2). Although they might not be diagnosed with PTSD, many veterans today have seen their peers severely injured, witnessed death, and experienced grief.

The Department of Defense Task Force on Mental Health reports that “female servicemembers in combatant areas have had to fight the enemy in the same manner as their male counterparts: engaging in firefights, taking
prisoners, and occasionally becoming casualties” (U.S. Department of Defense, 2007, p. 58). The current conflicts in Iraq and Afghanistan “are the first combat operations where a large number of female service personnel have had the potential for repeated exposures to combat situations. Repeat deployments have also added to the exposure potential” (U.S. Department of Defense, 2007, p. 58). The report cites conflicting findings from studies on the psychological effects of combat on women. Reports indicate that female veterans are more likely than their male counterparts to suffer from PTSD. This is also true within the general population, in which women suffer from PTSD at a rate twice as high as men (Perconte and others, 1993; Dobie and others, 2004). However, women are not as likely to be diagnosed with PTSD as men are. The authors of the Department of Defense report theorize that this may be based on cultural views that do not easily recognize women as combatants, as well as a tendency to diagnose women’s mental health problems as depression or anxiety rather than combat-related PTSD (U.S. Department of Defense, 2007). Added to these factors is a tendency for women to not define themselves as veterans after they have completed their service, coupled with women’s concern about maintaining the emotional and psychological strength expected of military members (U.S. Department of Defense, 2007). These issues can create barriers that prevent women from seeking treatment.

Throughout their deployment, military personnel experience the daily stress associated with combat readiness. Although technological advances have made it possible for military personnel to remain connected with their family while at war, servicemembers often find the combination of home and combat difficult to balance. They learn to compartmentalize their lives, bringing family and relationships to the forefront only when it feels safe and they can handle the merging of these two worlds. This phenomenon may carry over after separation from the military.

When women veterans share anecdotal stories that describe their frustration with returning to civilian life, they offer opportunities to understand their transitions. The day-to-day dramas and crises that plague the typical civilian woman may appear ridiculous and absurd when compared with the dangers of combat (Blankenship, 2008). Therefore, student affairs personnel need to be aware that the typical situations that are stressful or difficult for traditional college women likely will not affect women veterans in the same manner. This realization means understanding that how women veterans process and make meaning of their college experience will be influenced by how they are making meaning of their combat experiences.

**Sexual Assault.** *Military sexual trauma* is the term used to describe any sexual harassment or sexual assault that occurs in the military. While data specific to veterans of the current conflicts are unavailable, the U.S. Department of Veterans Affairs revealed that among veterans who sought health care through the Veterans Administration, 23 percent of women reported sexual assault while in the military and 55 percent reported some
form of sexual harassment (National Center for Posttraumatic Stress Disorder, 2007). While there are numerous statistics related to unwanted sexual conduct available, comparisons are difficult because the definitions used can include rape, sexual assault, sexual harassment, or any combination of the three categories. Findings from the “Department of Defense FY07 Report on Sexual Assault in the Military” revealed that 6.8 percent of women in the military reported unwanted sexual conduct (U.S. Department of Defense, 2008). Army statistics reported a much lower incidence of unwanted sexual conduct in the forward operating areas of Iraq and Afghanistan than in the Army at large, and that finding is attributed to high levels of unit cohesion in combat zones and tight restriction of alcohol consumption (Ryan, 2008). An additional study found that 78 percent of women experienced sexual harassment on active duty, while 6 percent had experienced rape (Vogt, n.d., p. 3).

Skinner and others (2000) discuss the specific impacts of sexual harassment or assault on military women. Feelings of loneliness and being left out were common adjustment issues reported upon return to civilian life by female military personnel who had experienced sexual assault. These women were likely to feel that their experiences would not be understood by their family and their peers. Anxiety, substance abuse, depression, and anger were all common reactions during readjustment (Skinner and others, 2000). Among those who reported military-related sexual assault, instances of depression were three times higher and incidents of alcohol abuse two times higher than among those who did not experience assault (Hankin and others, 1999).

Student affairs personnel need to be aware of the mental health problems that might affect female veterans when they attend college but should not assume that all female veterans arrive on campus with these issues. Rather, while most of returning women veterans will not show signs of mental health issues, many will struggle with how to make the transition to civilian life, including their role as a college student. In essence, they need to make meaning of what they have seen and experienced while at war. The process of meaning making is related to the idea of shifting from accepting knowledge from an authority to constructing knowledge for oneself, based on individual learning and experiences (Baxter Magolda, 2001).

Understanding the Identity Development of Women Veterans

Student affairs professionals often use psychosocial and identity theories to understand how individuals view their personal and interpersonal lives during college (McEwen, 2003). Understanding the development of women veterans requires making a connection between what these women experienced during their military service and how those experiences may or may not relate to how they make meaning of their experiences as college students. The growing population of women veterans on campus creates the
Meeting the Needs of Women Veterans

need for the development of a new framework for understanding how this student population views their collegiate experience. The reconceptualized model of multiple dimensions of identity (Abes, Jones, and McEwen, 2007) provides a framework for understanding the contextual influences that affect women veterans. The voices of military personnel are captured through anecdotal stories in the popular press or through limited studies conducted through the military branches, revealing that the context of the military is distinctly different from that of higher education. Moreover, the societal expectations that accompany experiences in the military and in higher education are also distinctly different. The multiple cognitive, intrapersonal, and interpersonal dimensions that influence how women veterans make meaning of their military experiences do not always connect with how they view themselves or how others on campus view them. This is especially true because few of their civilian peers can relate to what it means to be in the military. Abes, Jones, and McEwen (2007) state that a “key consideration in understanding students’ multiple identities is for student affairs professionals to acknowledge and understand the nature of contextual influences” (pp. 19–20). Student affairs administrators have the opportunity to engage students in discussions that could begin to bridge that contextual gap.

Life in the military is very different from what is experienced by the average freshman in college. Although freshmen may experience certain benchmarks as they learn to be more independent and establish an identity, colleges do not train students in the way that the military trains soldiers. An individual’s introduction to military life occurs during basic training, in which the mental and physical demands are significantly different from those placed on first-year students in college. Herbert (1998) stated, “The process of basic training is one of depersonalization and deindividuation in which the military, in the form of drill sergeants, must strip the individual of all previous self-definition . . . [B]asic training . . . is also intended to vest each participant with a clear notion of what it means to be a soldier, a Marine, and so forth. In the case of military training, these images are characteristically male” (p. 9). She further noted, “Women who enter a male-dominant setting must learn how to redefine and manage ‘femaleness’” (Herbert, 1998, p. 21). Herbert asserted that women in the military feel pressures to act either more feminine, more masculine, or both. Some women react by playing up their femininity through their attire, makeup, and surroundings. Others suppress their femininity or engage in more typically male behaviors such as swearing or drinking alcohol. Herbert also reported that women are often reluctant to allow others, especially men, to help them, even in circumstances where help is warranted, for fear of appearing weak. This reluctance to accept help was true for tasks that required physical strength as well as in other tasks that occurred during both training and service. In these cases, strategies were employed that often moved the individual away from natural expression of gender to a more forced and conscious one. This learning may be difficult to counteract upon
return to civilian life. Herbert's study was completed during peacetime, and it is likely that these pressures are even more prevalent in wartime.

The psychosocial outcomes of basic training as just described do not easily fit into the models of identity development that are related to traditional college students. Although it addresses specific components of Chickering and Reisser's (1993) “seven vectors,” basic training forces servicemembers into a pre-assigned identity that, in most cases, is highly valued only within the military community. As a result, when the structured military community is removed, the individual is forced to again redefine who she is as a civilian, a veteran, a female, and a student. In regard to gender development, the identity that was respected in the military is one that demonstrates male characteristics. Therefore, when women veterans re-enter civilian life, they are often unsure of how to fulfill not only their specific role as a student but also their role as a woman. The gender issue is distinctly different for men because they are often rewarded by society for displaying strong male characteristics.

Women veterans face other unique challenges as they return to civilian life and attend college. As Herbert (1998) reported, women in the military are forced into a more conscious and deliberate role as an armed force member and are not allowed a natural expression of gender. Through the work of Marcia, we understand that identity development occurs along two dimensions: (1) an awareness that an identity crisis exists and must be resolved and (2) the commitment to an identity (Marcia, 1966). Removal of the forced military identity causes a crisis of identity for female veterans as they struggle to re-assume roles as civilians.

Josselson (1987) explored how women develop a sense of self, mirroring the work of Marcia. Josselson would identify women veterans as “identity achievers” or “pavers of the way.” These women have formed a distinct identity in which their occupation is an expression of who they are as an individual. When their military occupation is removed and a new vocation must be found in a college or university setting, many women veterans face a unique identity crisis. The way in which they constructed meaning for their life is not appreciated on campus as it was in the military. As a result of this dissonance, women veterans need to socially construct a new identity that is specifically related to gender in order to make meaning of the collegiate environment.

Finally, the transitions that male veterans face when enrolling in college are likely facilitated by the presence on campus of male veterans among faculty and staff (see Chapter Two and Chapter Eight). Female veterans on campus are less likely than male veterans to find same-gender role models. In addition, while serving in the military, females had fewer same-gender role models than males did. When women veterans come to campus and face issues associated with establishing an identity, they will need to be able to find other women with whom to connect.
Suggestions for Practitioners

Working with women students who are veterans ideally involves an understanding of both gender identity issues and the transitions associated with moving from the role of active military member to that of a civilian college student. Understanding the specific issues associated with female veterans requires student affairs personnel to be aware of the multiple dimensions of identity development. These women likely need to make meaning of both their past and their present context. Gaining an understanding of how women veterans filter and process meaning making related to identity formation will provide student affairs professionals with a way to “effectively see [these] students as they see themselves by understanding not only what they perceive their identity to be, but also how they make meaning of their identity dimensions as they do, how they come to perceive identity dimensions as salient or relatively unimportant, and to what degree they understand their social identities as integrated or distinct” (Abes, Jones, and McEwen, 2007, p. 19). The challenge for student affairs professionals is to understand and value the experiences of women veterans so that they can be helped to define their sense of self in relation to the college campus and their civilian status.

As discussed elsewhere in this volume, campus leaders have responded to the growing number of student veterans by providing services to support that population. Student veteran centers, peer advising, orientation programs for veterans, and student veterans organizations are examples of the supportive initiatives that have been deemed helpful by veterans as well as by higher education leaders (Redden, 2008). Faculty and staff, especially student affairs educators who seek to support female veterans as they make the transition from combat to classroom, should consider the following topics in their discussions with students.

- What steps might you take to connect with other military veterans who are students on this campus?
- How might you begin making connections with other women on this campus?
- To what extent are you aware of the support services available to students?
- What are the sources of your stress as a student, as a female, and as a veteran?

Questions that focus on specific combat experiences may be difficult for veterans to answer. Many students may ask veterans these questions out of curiosity and not realize that the questions may evoke emotions or experiences that these students are still processing. When working with veterans on campus, it is best to avoid questions that directly relate to combat, including questions about having to kill another human being, having been shot or wounded, or having observed others in these situations.
Further Research

Women veterans’ needs on college campuses should be explored further through research. The majority of literature related to understanding a woman’s experience in the military comes from the popular press and military reports. Most of these sources of information focus more on providing personal stories than on presenting empirical research findings. Moreover, neither military training exercises nor the realities of being on the front lines of war are considered in any of the current models or theories associated with women’s development. An area of importance to higher education researchers and student affairs professionals is how military service affects gender development in women student veterans, a topic we touched on in this chapter.

As more women veterans enroll in college, practitioners should be aware of the unique needs of these students as they participate in all aspects of campus life. Directly related to this need for awareness on the part of educators is the need to help students who do not have military experience understand and appreciate this student population. How these conversations can best be approached in a manner that builds community and understanding needs to be explored.

References


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I'm A Sharpshooter: Chantelle Bateman

Siri Margerin

http://www.ivaw.org/war-is-trauma
On War and Waves

The first time I came home from Iraq, I knew something was off when I found myself literally burning rubber backing my car out of my parents’ driveway in LA. It was July 2003, and this young reservist was home from the war. I had always been a mellow driver, but I gunned my car and screamed down the street doing sixty. *Why do I feel so antsy?*

It was like that for the next month as I prepared to go back to school in San Diego. I would race down every street, brush past people on the street as I power-walked past them, and tapped my foot constantly. Anxious. Impatient.

I couldn’t pin it down. Sure, I had been in a few (very few) dicey situations in Iraq, but I didn’t think I had Posttraumatic stress disorder (PTSD). Not me. I wasn’t traumatized by what I saw. I didn’t have nightmares or feel the need to sleep on the floor. But I did drive like a maniac, couldn’t stand waiting in line, and every morning when I woke up, I reached for my rifle.

It didn’t help that when I made it down to San Diego, I practically had to give my school registrar a pound of flesh to convince them to let me back in. When they first told me that I had to re-apply, I came home and slammed the door shut. I threw my car keys against the wall, kicked over a chair, and screamed. *I went to war for you. I just want to go back to school. Why are you doing this to me?*

It could have gone downhill from there. I know for some guys and gals, it has.

But it didn’t for me. Because the chair that I kicked landed next to my surfboard. I had bought the board before I deployed, but I never really learned how to surf. As I picked up the chair, I caught a whiff of the wax on the board. It smelled sweet, like those sugary fruit punch juice boxes you got when you were a kid. It smelled happy. I picked up the chair and told myself that I might as well go to the beach.

The ocean doesn’t care if you went to Iraq. The first time I went out, the crest of a wave dropped on top of me as I was trying to paddle out. A few hundred pounds of water poured over me, sending me tumbling end over end. It didn’t care that I was just home from Iraq. I popped up to the surface, gasped for air, and inhaled the next wave that hit me. When it was all over, I was lying on the beach, coughing and gasping. Two pre-teen girls laughed as they splashed past me with their surfboards.

As the water drained out of my nostrils (a novel sensation, by the way), something clicked. Here was a way to channel all that nervous energy into something positive. I was going to learn how to surf.

For the next month, I went out every day. I watched other surfers sink their boards under the oncoming waves as they paddled out. I learned how to sit calmly on my board as I waited to for the swell to pick up. I paddled hard to catch those elusive, moving mountains of water, but even though I was now good enough to not get pummeled trying to paddle out, I wasn’t hanging ten.

Two weeks after my first outing, it finally happened. I saw the wrinkle in the glassy ocean in the distance, watched it grow. *This was it!* I lay down on my board and paddled long, deliberate strokes. I glanced behind me, feeling the wave pick up the tail of my board. The giant hand of the ocean grabbed my board and flung it forward. I felt like I was going a hundred miles an hour as I slid down the face of the wave. I laughed with glee as I held onto my board as we rocketed towards the shore. It was the first time I had laughed since I came home from Iraq.

That laugh broke the dam. I calmed down. I was a different man when I walked back to my car that day. I started driving at the speed limit (well, maybe just slightly above). I patiently navigated the
university bureaucracy until I was registered for classes in the fall. My heart didn’t beat so fast and I didn’t feel so angry anymore. I landed a student job as a security guard on campus. And I surfed every day.

It took me years to realize that surfing took my nervous energy and channeled it into something beautiful. Watching the sun dip low over the waves as I sat on my board made me exhale and shake my head in amazement. I began to get better at riding the waves, carving graceful lines through the breaking surf before leaping off my board into the churning white water. Sitting on my board bobbing on the water, I took stock of all I had seen and I had done. This ocean that was indifferent to my service, but it had a marvelous calming effect that allowed me to pick my own brain and come to grips with everything that had happened. By the time I sat down with my more carefree classmates in the fall, I was ready to be normal again.

And so the lesson I want to pass on to everyone is this: do something when you come home. We all don’t have PTSD, but we all come back different. A lot of us probably have that nervous energy that I described. Do something with it. Hike. Swim. Bike. Cook. Make model airplanes. Do something that consumes your whole mind when you come home. Follow through with it. This doesn’t replace the invaluable help from the Wounded Warrior organizations in the Army and Marine Corps, or the folks at the VA for those who have serious problems, but it does help all of us who come home bewildered and struggling to reconcile all the outrageous, beautiful, tragic, hilarious, and pointless things that we volunteered to do. And if you’re in San Diego, give me a holler. I have two boards now. I’ll ride with you.

Jonathan Wong joined the Marines Corps in 2001 and deployed to Iraq twice as an infantryman. He is returning to school in September to earn at Ph.D. in policy analysis at the Pardee RAND Graduate School in Santa Monica, Ca.
When ‘thank you for your service’ falls flat
By Phillip Carter, Special to the BDN
Posted Nov. 07, 2011, at 7:14 p.m.

I remember the first time I was thanked by a stranger for my military service. It was February 2006, and I was on the way home for mid-tour leave with a planeload of other troops from Iraq and Afghanistan. Our plane stopped in Bangor, Maine, like thousands of similar flights before and after ours. One by one, garbed in dusty camouflage, we walked into the terminal.

I was expecting an empty airport, but instead we were met by a platoon of older volunteers decked out in red-white-and-blue, welcoming us home with cookies and cellphones so we could call our families and let them know we were back stateside. One by one, the volunteers thanked us, shaking our hands or hugging us.

The display of patriotism and gratitude surprised me, and I wasn’t sure how to respond. Just a few days before, I had been living with my team in squalor on a small compound in downtown Baqouba, Iraq. Now, I was in a comfortable suburban airport, being handed treats by somebody’s grandparents and treated like a returning hero. I couldn’t understand why they were thanking me, with only half my tour done and a great deal of work left in Iraq before we could rightfully claim success. I stuffed those feelings away, though, muttered something to myself about focusing on the vacation ahead and quickly found a corner of the airport where I could wait with other soldiers for our flight to resume its journey to Dallas, where we’d all catch connecting flights home.

Several months later, my team and I came home from Iraq for good. Once again, the thank yous began, except this time they hit me differently. The first came from a general who spoke to our welcome-home ceremony at the airfield at Fort Campbell, Ky. I heard him offer several platitudes — thanking us, calling us “heroes” — that seemed like the sort of thing a general is expected to say at such a moment, but they also felt disconnected from the state of the war. The “hero” label, in particular, didn’t feel right to me. Most of us did nothing heroic in Iraq; we merely volunteered to serve and went to war, in the same way that a firefighter volunteers for work and then runs into a burning building. We came home just before Gen. David Petraeus took over and the troop surge began, at a time when thousands of Iraqis were dying each month in a hellish civil war. If we were really heroes, why was the war in Iraq going so badly?

I struggled to reconcile the general’s gratitude with my mixed feelings about Iraq, and how our efforts had done little to stop the violence there, and I came up empty.

Two weeks after redeploying from Iraq, I returned home to Los Angeles. There, “thank you” was less frequent. My family and friends welcomed me with more intimate questions based on the stream of emails I had sent from the war. They asked what had happened to the interpreter I’d befriended, or what came of the program we developed to issue blue-painted Humvees (we called them “Smurfvees” to the Iraqi police, or whether traffic was worse in Baghdad or Los Angeles (hands down: Baghdad). Other veterans, recognizing the Army patch on my baseball cap, or the tan Under Armour gym shirt I wore everywhere, sometimes said hello and asked where I had been and how I was doing. But with few veterans around me in L.A., those inquiries were rare.

Strangers, however, mostly said nothing. Perhaps they lacked any connection to the war or had nothing to say, even if they recognized me as a veteran. Which was fine, because I didn’t have much to say to them. In my first few months home, I felt alienated from the civilians around me. I resented the way everyone continued their lives, as if there were no war at all. I couldn’t understand how the nation that sent me to Iraq could care so little about the war. I withdrew, spending time only with close friends — usually other veterans — and even pushing away family because I felt I had few things in common with them. I spent entire days doing little but walking on the beach with my dog, wearing sunglasses and listening to an iPod, so I could be alone with my thoughts.

I even resented the strangers who thanked me; I suspected that they were just trying to ease their guilt for not serving. Instead of thanking me, I wanted them to do something tangible for their country, to make some sacrifice greater than the amount of lung effort necessary to utter a few words. I also wanted them to do more to understand...
what was happening in the war — Pick up a newspaper! Get involved with a local veterans group! Visit a recruiting office and enlist! — so they could really comprehend what they were thanking us for.

Perhaps my reaction was irrational. Fewer than 1 percent of Americans serve today in uniform. We neither need nor want nor can afford a massive military made up of draftees from every part of American society. For the wars we are in — and the likely future wars of the 21st century — we will need something like the all-volunteer, professional force we have today. And yet, absent conscription, we will probably never bridge the civilian-military divide that has grown during the four decades of the all-volunteer force. It simply isn’t realistic to expect every American to have a personal connection to the military, even in wartime. Intellectually, I’ve realized the futility of resenting people for going on with their lives while my comrades and I fought for them in Iraq and Afghanistan.

Emotionally, too, I’ve made some peace with the demons I brought home from Iraq. I became comfortable talking with people about the war and started writing about it as well, to gain some perspective on this experience. I talked with counselors at the VA hospital in Los Angeles; they helped me learn to live with my combat experience and translate it to the civilian world. My friends reached out and pulled me back into their lives, even if I didn’t always want to be social. I eventually learned to talk with them about the war and listen to them about their feelings toward veterans — and why they felt compelled to thank us.

Through these conversations, I began to understand the sincerity underlying most gestures of gratitude toward the troops. I also began to empathize with those who had no personal connection to the military, but who still wanted to say something or do something to support those who served on their behalf. There is genuine respect behind those thank yous, and after a while, I came to accept that.

I also believe that this collective gratitude may serve a deeper purpose. Whether civilians fully realize it or not, the simple message of thanks sends a powerful message to veterans — that the nation will take responsibility for our actions in her service. In some small way, this collective acceptance of responsibility helps veterans to transfer some of the psychological burdens of wartime service to society. Such gratitude will not eradicate combat stress or address every veteran’s experience. However, these small gestures do make a difference.

Despite my initial misgivings, I’ve come to see “thank you for your service” as the right greeting to use for returning veterans. It is neither too intimate, nor too invasive, nor too distant, and it correctly captures the sentiment of a grateful nation for those who serve in harm’s way. Saying thank you avoids the much more pernicious questions that every combat veteran hates, questions such as “What was it like?” or “Did you kill anyone?” Simple statements of gratitude also avoid labeling veterans as heroes or victims, two moral judgments that can be made only on an individual basis, if at all.

I now live in Arlington, Va., one of the densest military communities in the nation. Although I frequently see active military personnel and veterans in the neighborhood, I rarely stop anyone to say hello, much less say thank you, in part because I remember how reluctant I was to accept those thanks when I came home. I should do so more often, though, lest the sentiment be offered so rarely that it is forgotten.

Phillip Carter, an Iraq war veteran, is a founding member of Iraq and Afghanistan Veterans of America and former deputy assistant secretary of defense for detainee policy. He is now the chief operating officer for Caerus Associates, a strategy and design consulting firm.

http://bangordailynews.com/2011/11/07/opinion/contributors/when-%e2%80%98thank-you-for-your-service%e2%80%99-falls-flat/ printed on May 17, 2012
Oma Died, by Niels Daaman

1. Niels, Oma died...Mom, I am getting deployed

3. Please put your M-16 in the overhead compartments with the muzzle facing to the rear of the plane.

12. Release chaff...Fuck we haven't even arrived yet, and already we're getting shot at?


11. Alone. People say I'm not, but where are they then?

13a. Someone has been in my bedroom.

9. I can't believe you told everyone! What were you thinking?
   I was hurt&you don't understand.

4. 1st Casualty. Now it is on boys.
   Fuck...it's been on since the first scud flew over.

5. At least I didn't really know him. There will be more.

7. Cross the border to Kuwait. Relief, breathe.
   Two weeks later downtown Baghdad again; disillusioned.

2. We're taking the church bus to war.

13. No longer home, still alone.

6. GAS, GAS, GAS!!!!

15. I bought a shotgun, that wasn't smart.

16. I can't go back. I can't go back! PLEASE.

10. I wish I were dead.

18. I'm going to the morgue and overdose.

17. Going to drill exacerbates his symptoms.

20. Doig and Dorris and Wright are going back. Maybe I should?

14. I'm hurt. I'm weak.

19. Where have all my tears gone?

Niels Damman, US Army Reserves, Iraq
THE WARRIOR AT HOME
by Melissa Eaton
2/28/2009

My man has been to battle
My man has been to war.
And it's really hard to realize
He's not the same man I knew
before

I know I'm not the reason
He sits and cries in the dark alone
With memories of terrors
Even though now he's safe at home

But he's my hero
My wounded warrior Love
He fought hard to win our freedoms
But somehow he lost his soul..........
How do I try to help him?
Now his job is finally done
For he still suffers and is haunted
By this war that he's brought home,

I must remind myself each moment
As the dishes hit the wall
It's not me that caused his anger
I'm not the real target, after all

I try to comfort him at nighttime
He cries out, and is soaked with sweat
Dreams of death are all around him
His war still rages in his head

He medicates himself with danger,
Drugs and porno and the wine
I'm so afraid he'll overdose it
And be forever gone from time

But they're our heroes
Our wounded warrior Loves
They fought hard to win our freedoms
But somehow they lost their souls....
How do we try to help them?
Now their jobs are finally don
For still they suffer and are haunted
By this war that they've brought home

There's no end in sight
To this endless war
That they've brought home.
somebody called us
broken toy soldiers...
somebody said we were swept
under the rug...
somebody said we fought
for freedom...
somebody said we fought
for empire...
somebody thanked me
for my service,
and i felt confused...
because i forgot what i fought for,
but now i know.
so i’m taking back what you took.
i see through your symbols.
so i will destroy them
and make them beautiful.

Broken Toy Soldiers by Eli Wright, 2009

Serigraph on sutured Combat Paper
33 x 28