

Post-traumatic Stress Disorder and the Casual Link to Crime: A Looming National Tragedy

A Monograph

by

MAJ David L. Daniel

United States Army



School of Advanced Military Studies

United States Army Command and General Staff College

Fort Leavenworth, Kansas

AY 2007 - 2008

REPORT DOCUMENTATION PAGE				Form Approved OMB No. 0704-0188	
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.					
1. REPORT DATE (DD-MM-YYYY)		2. REPORT TYPE AMSP Monograph		3. DATES COVERED (From - To) July 2007 - April 2008	
4. TITLE AND SUBTITLE Post-traumatic Stress Disorder and the Casual Link to Crime: A Looming National Tragedy				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Major David Daniel				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Advanced Military Studies Program 250 Gibbon Avenue Fort Leavenworth, KS 66027-2134				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES) Command and General Staff College 1 Reynolds Avenue Fort Leavenworth, KS 66027				10. SPONSOR/MONITOR'S ACRONYM(S) CGSC	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION / AVAILABILITY STATEMENT Approved for Public Release; Distribution is Unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT: See Abstract.					
15. SUBJECT TERMS PTSD, crime, criminal behavior, DOD corrections					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT UNLIMITED	18. NUMBER OF PAGES 58	19a. NAME OF RESPONSIBLE PERSON Stefan Banach, COL, US Army
a. REPORT UNCLASS	b. ABSTRACT UNCLASS	c. THIS PAGE UNCLASS			19b. TELEPHONE NUMBER (include area code) 913-758-3302

SCHOOL OF ADVANCED MILITARY STUDIES

MONOGRAPH APPROVAL

Major David L. Daniel

Title of Monograph: Post-traumatic Stress Disorder and the Casual Link to Crime: A Looming National Tragedy

This monograph was defended by the degree candidate on 14 April 2008 and approved by the monograph director and reader named below.

Approved by:

Jacob W. Kipp, Ph.D.

Monograph Director

Matthew T. Higginbotham, COL, QM

Monograph Reader

Stefan J. Banach, COL, IN

Director,
School of Advanced
Military Studies

Robert F. Baumann, Ph.D.

Director,
Graduate Degree
Programs

Abstract

A SAMS MONOGRAPH by Major David L. Daniel, United States Army, 58 pages.

Soldiers returning from service in the Global War on Terror may experience a high incidence of varying degrees of Post-traumatic Stress Disorder (PTSD). As such, the military leadership and society in general must, therefore, develop an in-depth understanding of PTSD and the effects that a high occurrence of this disorder in veterans and serving personnel will have on our society. The purpose of this paper is to investigate if there is a correlation between PTSD and criminal behavior in soldiers that have been incarcerated after returning from the GWOT and to determine the obligations of the U.S. government/DoD to prevent, treat, and/or mitigate the problem.

This study includes data collected, examined and analyzed from three primary sources. First, an existing study on PTSD and criminal behavior by James J. Collins and Susan L. Bailey which examines the correlation between PTSD and criminal behavior primarily in 1140 non-veteran North Carolina inmates. This study is included to establish whether a general causal link exists between PTSD and an incidence of violent criminal behavior. Next, statistical data compiled by the Bureau of Justice Statistics (BJS) section of the Office of Justice Programs, U.S. Department of Justice (DoJ) is analyzed for trends in incarceration rates among veterans in Federal and State correctional facilities. The BJS data is included to examine whether the incarceration rates of veterans for violent criminal offenses has peaked during and after periods of war. Finally, this study will look closely at aggregate exempt inmate data recently compiled by the administrative and mental health staff of the United States Disciplinary Barracks, Fort Leavenworth, Kansas (USDB). The data from the USDB is part of an ongoing survey of the inmates (n=440) to determine the incidence of PTSD and mental health disorders within the prisoner population for treatment purposes and program analysis.

This paper explores the history of PTSD in previous conflicts, the characteristics of the disorder and briefly discusses current treatment approaches. The data presented, particularly the initial results of the current USDB survey, strongly supports the current hypothesis that there is a correlation between PTSD and criminal behavior in soldiers that have been incarcerated after returning from the GWOT. As such the final contribution of this paper is to offer some brief recommendations on what our national leaders should do to prevent or mitigate the impending problem in our society of more veterans involved in violent criminal behavior.

To Captain Donald L. Brakeville, United States Army National Guard, Washington State with whom I had the honor of serving for a brief time in 2006 while he was my Battalion Rear Detachment Execution Officer of the 508th Military Police Battalion at Fort Lewis, Washington. Don served and was wounded in Operation Iraqi Freedom, but was well on his way to a physical recovery. Although we may never be certain of Don's dire motivations, some wounds don't heal however, and Don chose to take his own life on 22 March 2008. Don is survived by his wife and two children – he will be sorely missed. Perhaps some of the information contained in this monograph may help other Soldiers by offering our leaders some knowledge about PTSD and recommendations to aid in solving what could be a national tragedy on the horizon.

ACKNOWLEDGEMENTS

I would be remiss if I didn't take the opportunity to thank those who but for their support, I would certainly have not finished this monograph. First, my wife Carla and my children: Patrick, Elise and John. Without the patience, love and understanding of my family, I would have surely succumbed long ago to some of the symptoms I discuss in this paper. Secondly, my thanks extend to Ms. Maria Clark of the Quality Assurance Office of the Command and General Staff College, Fort Leavenworth, Kansas. Ms. Clark got me started on the right track from the onset of this project – without her guidance early on; I would not have focused my efforts on this very difficult and important topic and narrowed the scope of this research to something manageable given the broad range of issues surrounding post-traumatic stress disorder. Finally, my deep gratitude goes out to Dr. Ellen Galloway and the whole staff of the United States Disciplinary Barracks, Fort Leavenworth, Kansas for without their assistance, this paper would have been impossible.

TABLE OF CONTENTS

CHAPTER I	1
INTRODUCTION	1
METHODOLOGY	4
LIMITATIONS	6
A FRAMING OF THE PROBLEM	8
Historical Perspective of Post Traumatic Stress Disorder	8
Understanding Post Traumatic Stress Disorder	16
Vietnam Experience and Parallels with the GWOT	23
Theories on a Causal Link Between PTSD and Criminal Behavior	29
CHAPTER II	33
REVIEW OF THE RESEARCH DATA	33
DISCUSSION	44
RECOMMENDATIONS	46
CONCLUSION	53
BIBLIOGRAPHY	55

CHAPTER ONE

INTRODUCTION

There are accounts of brutality and violence to be found from each and every war in man's history. Equally disturbing is that in each conflict many veterans end up suffering from very debilitating mental disorders – some of which lay dormant until long after the event that psychologically scarred the veterans. We now know that it is post-traumatic stress disorder (PTSD) that many veterans succumb to either as an acute or chronic disorder. Herbert Hendrin and Ann Haas discuss how in earlier wars, not much was understood about the disorders veterans suffered from without any clinical support.¹ Hendrin describes how many French soldiers were found to be suffering from “nostalgic” homesickness during the Napoleonic Wars—really a kind of detachment from their surroundings. Likewise, Hendrin relates that soldiers of both the North and South appeared to be afflicted by an “irritable heart” as the condition was known during the American Civil War.² Unfortunately, performance in combat was seen in black and white terms of either a soldier had what it took or was simply a coward.³ Actually, World War I is when the symptoms now associated with PTSD were first tied to the prolonged exposure to sustained combat.⁴ Two common terms used during the World Wars for the stress-associated disorders of veterans was “shell shock” and “combat fatigue” for the First World War and Second World War, respectively.⁵ It was commonly thought that the disorders were transient and symptoms would diminish fairly rapidly once the veteran left combat.⁶ In fact, following World

¹ Herbert Hendrin and Ann Pollinger Haas. *Wounds of War: The Psychological Aftermath of Combat in Vietnam*. New York: Basic Books, Inc. 1984, 15.

² Ibid., 16.

³ Ibid., 16.

⁴ Ibid., 15.

⁵ Richard J. McNally. *Remembering Trauma*. Cambridge, Massachusetts and London, England: The Belknap Press of Harvard University Press. 1994, 9.

⁶ Ibid., 9.

War I a commission of civilian psychiatrists found that over ninety percent of soldiers suffering from what they termed “temporary psychological disorganization” or war neurosis had found that their “acute reactions subsided after a brief period away from combat.”⁷ However, many of these same individuals had difficulty re-integrating into society.

With each successive conflict throughout history authorities, physicians, psychiatrists and soldiers alike re-visit the subject of combat stress and the associated disorders. Each group has its own motivations for examining the phenomena of combat and why some individuals develop disorders while others do not show any signs of trouble. Perspectives and theories on the causality of extreme combat stress disorders are as varied as the treatments that have been developed to combat the syndromes. More often than not, these theories and treatments are misguided or politicized causing more harm to veterans than having done nothing.

Critical to any examination of combat stress disorders, or PTSD, is an in-depth knowledge or understanding of what PTSD actually entails. Key to understanding is examining who is susceptible, what are the symptoms, what variables affect prevalence of the disorder and what can be learned from the experience of previous wars. In researching the literature on PTSD, one can make attempts at predictive analysis for future conflicts and perhaps more importantly, what negative effects a high prevalence of PTSD can have on a society.

As America passes its seventh year anniversary of the Global War on Terror (GWOT) and has endured six years of sustained operations in Afghanistan and nearly five years of constant operations in Iraq, social issues that had faded in our collective mind have re-emerged. Combat operations in Afghanistan and Iraq are dredging-up disturbing memories for some individuals while others are reminded of serious reintegration problems that plagued many veterans from previous wars. Specifically, Post Traumatic Stress Disorder (PTSD) and the specter of veterans seriously afflicted and disturbed by their combat experiences haunt many individuals, veterans

⁷ Hendrin, 25.

groups, mental health professionals and policy-makers.

To speak only of the resurgence of PTSD in Vietnam veterans, Gulf War veterans and a surge in cases of the disorder in GWOT veterans as a contemporary issue belies the true scope and potential severity of this latest rendition of the problem. Nevertheless, it is a contemporary topic which is eliciting great interest in all sectors of our society as evidenced by the amount of recent media coverage of the subject. Most recently, in October 2007, an article about the casualties of the GWOT by Michael Isthoff and Jamie Reno appeared in *Newsweek* magazine. The article reported on a Veterans Administration (VA) study which placed the rising numbers of PTSD cases from the GWOT "...from 29,041 a year ago [2006] to 48,559 this year."⁸ Isthoff and Reno also quote a Harvard University policy analyst who stated that the estimates regarding projected costs for disability and care over the next ten years are well below what will be the reality.⁹

Additionally, Heidi Rafferty recently wrote in the November 2007 issue of *Veterans of Foreign Wars (VFW) Magazine* that the VA has seen an increase of Vietnam era veterans looking for services in VA clinics for a resurgence in their symptoms of PTSD.¹⁰ Rafferty explains that one of the reasons for this increase is that Vietnam veterans are experiencing a re-emergence of their own symptoms because they are reliving their trauma(s) while watching continual media coverage of the U.S. campaigns in Afghanistan and Iraq.¹¹ Moreover, studies as recent as Dr. Charles W. Hoge's (et al), in the July 2004 volume of *The New England Journal of Medicine* have begun to examine the current incidence of mental health disorders of Soldiers returning from duty in the Afghan and Iraq theatres of the Global War on Terror (GWOT).¹² In understanding

⁸ Michael Isthoff and Jamie Reno. Veterans: "How Do You Fund a War, But Not the Casualties?" *Newsweek Magazine*, 10.

⁹ Ibid., 10.

¹⁰ Heidi Rafferty. "Ghosts and Demons": Vietnam Vets Coping with PTSD., *VFW Magazine*, 20.

¹¹ Ibid., 20.

¹² Charles W. Hoge, M.D., et al. Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. In *The New England Journal of Medicine*, Vol. 351:13:22, 2004. Retrieved 11 August 2007 from URL: <http://content.nejm.org/cgi/content/full/351/1/13>

the experiences of past veterans with PTSD, to include resulting criminal behaviors, one can begin to make predictions regarding PTSD in veterans returning from service in operations supporting the GWOT and the effect the disorder will have on the military and society as these veterans reintegrate into the community.

Soldiers returning from service in the GWOT may experience a high incidence of varying degrees of PTSD. As such, the military leadership and society in general must therefore develop an in-depth understanding of PTSD and the effects that a high occurrence of this disorder in veterans will have on our society. This paper will investigate if there is a correlation between PTSD and criminal behavior in soldiers that have been incarcerated after returning from the GWOT and what are the obligations of the U.S. government/DoD to prevent, treat, and/or mitigate the problem.

METHODOLOGY

This current study includes data collected, examined and analyzed from three primary sources. First, an existing study on PTSD and criminal behavior is identified and included. The study (conducted in 1983), by James J. Collins and Susan L. Bailey, examines the correlation between PTSD and criminal behavior primarily in 1140 non-veteran North Carolina inmates. This study is included to establish whether a general causal link exists between PTSD and an incidence of violent criminal behavior. Collins and Bailey focused on determining if there is a correlation between violent criminal behavior and PTSD in primarily non-veterans “where the precipitating traumatic event for *most* was not associated with combat.”¹³ Only some 16% of their study population reported active military service. Collins and Bailey used professional, objective personnel to conduct one-on-one interviews using the “Diagnostic Interview Schedule (DIS)

¹³ James J. Collins and Susan L. Bailey. Traumatic Stress Disorder and Violent Behavior. In *Journal of Traumatic Stress*, Vol. 3, No. 2, 1990. Obtained through the CARL., 205.

(Version III)” questionnaire to determine the presence of PTSD symptoms in their sample population from the North Carolina prison system while factoring for past criminal history and demographic information.¹⁴

Next, statistical data compiled by the Bureau of Justice Statistics (BJS) section of the Office of Justice Programs, U.S. Department of Justice (DoJ) is analyzed for trends in incarceration rates among veterans in Federal and State correctional facilities. If, indeed a correlation exists between PTSD and criminal behavior, one would expect to see the incarceration rates of veterans for violent criminal offenses to peak during and after periods of war. As such, this study is looking to observe this phenomenon during past American wars and specifically as a result of the campaigns in Afghanistan and Iraq.

Most significantly though, this study will look closely at aggregate exempt inmate data recently compiled by the administrative and mental health staff of the United States Disciplinary Barracks, Fort Leavenworth, Kansas (USDB). The data from the USDB is part of an ongoing survey of the inmates (n=440) to determine the incidence of PTSD and mental health disorders within the prisoner population for treatment purposes and program analysis. At the time of this writing, the mental health staff, led by Dr. Ellen Galloway has completed the initial tier of a three tier study designed to identify inmates with PTSD, assess their individual circumstances and formulate treatment regimens for each affected prisoner. The data gained from Dr. Galloway’s efforts will be essential to assess the validity of the hypothesis that there is a correlation between PTSD and violent criminal behavior that resulted in the incarceration of the soldiers, seaman, marines and airmen at the USDB. The USDB staff administered a survey to the current inmate population that elicits responses to measure and allows for the examination of the following data:

- Deployment history
- Exposure to combat and injuries/wounds received in combat
- Prior diagnosis of PTSD
- Prior mental health counseling

¹⁴ Collins and Bailey, 2006.

- Presence of PTSD symptoms in the survey population

LIMITATIONS

The previous study (Collins and Bailey) does not purport to be able to definitively show a causal link in their targeted populations between PTSD and the propensity to commit a violent criminal act; however, the study shows significant empirical data to support their hypothesis and thereby demonstrates a significant probability that PTSD is a factor that influences veterans to commit violent crimes leading to their eventual incarceration either in a DoD correctional facility or a Federal or State institution. Moreover, the Collins and Bailey study rely on a relatively small survey sample to derive their conclusions. Collins and Bailey's group of survey respondents does, however closely match national demographic representation within State institutions making their study more reliable in making generalizations about the national population as a whole.¹⁵

The BJS Section's statistics on incarcerated veterans does not show a causal link between PTSD and their incarceration; rather the data merely addresses whether there has been an increase in veteran incarcerations for violent offenses that, should this study's hypothesis hold true, one would expect to coincide with periods of war. Likewise, the administrative data collected from the USDB regarding incarceration numbers (specifically, yearly average inmate populations) does not validate the current hypothesis but rather it only demonstrates whether the inmate population has increased during wartime as expected. Additionally, data does not exist within the USDB archives for complete offense breakdowns by year, thus only the available partial data was examined leaving a gap in the results. Neither set of statistical data factors in how many of the offenders were National Guard, Reserve or Active Duty personnel which may have skewed the

¹⁵ Collins and Bailey, 206-207.

numbers due to there simply being more soldiers federalized during the war.

Finally, in using the aggregate exempt inmate data from the USDB mental health survey, three areas are problematic in analyzing the results and using them to formulate empirical evidence supporting the current hypothesis. First, Dr. Galloway built a type one error (or false positive error) into the study in order to not miss a potential diagnosis of PTSD in any one of the inmates. The intent, of course, is to ensure all inmates are monitored and receive appropriate care. The second tier of the study involves detailed interviews and diagnostic evaluation to properly identify those inmates who have a bonafide diagnosis of PTSD, thus at this time, the standard deviation is unknown as the USDB study continues. Furthermore, the salient nature of incarcerations and releases at the USDB on a near daily basis complicates the process of analysis due to the introduction of new data based off inmate admissions mental health intake surveys and the fact that Dr. Galloway's team conducted the survey over the course of four months (August 2007 – November 2007). Accordingly, this study looked at the data available from the four month period and uses averages from that time period where necessary and exact numbers where possible to formulate results in an attempt to validate the current hypothesis. Again, one of the difficulties (as with the previous studies) remains that one cannot show a definitive causal link between the inmates' PTSD and their actions which caused their incarceration. Thirdly, the USDB survey (like the aforementioned 1983 surveys) relies on the truthfulness of response and voluntary participation in the process by individuals who may have there own agendas for how they respond to particular questions – a fact which may or may not effect the validity of any findings herein.

A FRAMING OF THE PROBLEM

Historical Perspective of Post Traumatic Stress Disorder

The aftermath of conflict has, throughout history, seen millions of casualties many of whom suffered no external wounds; rather they suffered from debilitating psychological trauma – some for the remainder of their lives. As warfare has progressed into the technological age and become more lethal, the number of psychological casualties has grown in numbers just as casualties from physical combat wounds has increased. John Keegan discusses this evolution in warfare in his work, *The Face of Battle*. Keegan details the progression of armed combat from bow, blade and cavalry to modern industrial warfare and captures the ferocity of battle using three historical examples: Agincourt in 1415, Waterloo in 1815 and the Somme in 1916. Keegan points out that what is important to note, other than that “the rise of industry has enormously enhanced the power which states can deploy against each other in war”, is that one constant has been that “men can stand only so much of anything (and dead men are dead whether killed by arrow or high-explosive).”¹⁶ Hence, Keegan argues more importantly that “the mechanization of battle has” acted to appreciably expand “the strain thrown on the human participants” in war.¹⁷ Fortunately, as the number of psychological casualties have increased, so too has the understanding of what afflicts these veterans. Mercifully, the treatment these war-weary veterans receive has also improved.

Prior to the wholesale slaughter of soldiers during the American Civil War, as Smith notes, any type of behavior which displayed “an incipient unwillingness to fight” was labeled as cowardice and punished severely.¹⁸ Smith points out those emotional reactions were construed to

¹⁶ John Keegan. *The Face of Battle*. New York, New York: Penguin Books. 1976, 304.

¹⁷ Ibid., 304.

¹⁸ John Russell Smith. *A Review of One Hundred and Twenty Years of the Psychological Literature on Reactions to Combat from the Civil War Through the Vietnam War 1860-1980.*, 23-25.

be cowardice and that this abnormality was due to some “preexisting character defect.” Thus, authorities based their attitudes and policies on the flawed causal connection “between emotional reactions, unwillingness to fight, cowardice and preexisting character defect.”¹⁹ In a macho era dominated by the concepts of bravery, courage and the glory of war, no attempt was made to exact a more scientific causal link to explain a soldier’s emotional disorder, desertion or other severe combat reaction.

With the Civil War, came a fundamental shift in the thoughts regarding the causality of combat reactions. Smith writes that authorities could no longer rely solely on the idea that a preexisting character flaw was responsible for why soldiers experience severe emotional reactions to combat and thus lose the desire to continue the fight.²⁰ There is an acknowledgement during this time that severe combat reactions “occur in normal as well as disordered populations.”²¹ Smith contends that this change in thought was precipitated by the large numbers of soldiers experiencing some form of severe combat reaction – “even among the most courageous of soldiers.”²² Numbers so large in fact that, according to Weaver and Stewart of the Army Research Institute, the Union had just over five thousand soldiers between April 1861 and March 1862 become casualties due to “nostalgia”²³

Authorities now focused on whether severe emotional disturbances were of short or long duration and how an individual coped with these disorders.²⁴ Similarly, authorities began to identify those personnel who succumbed to emotional combat reactions and that were able to regain their composure and ability to fight as worthy of treatment and thus afforded more “sympathetic” accommodations by the military psychiatrists. On the other hand, those

¹⁹ Smith, 25.

²⁰ Ibid., 26.

²¹ Ibid., 28.

²² Ibid., 20.

²³ Suellen F. Weaver and Nora Kinzer Stewart. *Factors Influencing Combat Stress Reactions and Post-Traumatic Stress Disorder: A Literature Review*. U.S. Army Research Institute for the Behavioral and Social Sciences. Alexandria, Virginia: Department of the Army. 1988, 1.

²⁴ Smith, 28-29.

individuals who succumbed to the symptoms associated with “irritable heart” and persisted in professing “their reluctance to fight” continued to be viewed as cowards and as a result were treated harshly.²⁵ Weaver and Stewart write that even before the Civil War, physicians noted that soldiers afflicted with “nostalgia” suffered from physical symptoms including “insomnia, weakness, loss of appetite, anxiety, cardiac palpitations, stupor, and fever.”²⁶ Furthermore, Weaver and Stewart identify that between the end of the Civil War and World War I, physicians and psychiatrists focused on the physiological aspects of “nostalgia.”²⁷ This acknowledgement of physical symptoms essentially began a debate that rages even today regarding physical versus psychological causes of PTSD.

According to Smith, throughout the 19th and 20th Centuries, the pendulum of theories or perspectives on the reactions to combat reactions has swung back and forth between “predisposition” and “occasion.”²⁸ That is, causality is thought to be either due to preexisting mental weakness or as a normal reaction to the extreme circumstances of war respectively. Predisposition, Smith argues, was the dominant perspective at the beginning and end of World War I.²⁹ Emotional reactions to combat “resulted from a pathological failure in the self-control of fear” due to an individual’s preexisting mental weakness or “predisposition, mainly consisting of personal and family’s histories of mental disorders.”³⁰

As with the Civil War, combat and environmental conditions in World War I were extremely horrendous. Combat in World War I was characterized by attrition warfare on an industrial scale creating enormous numbers of casualties. Binneveld illustrates the scale of death by citing two horrific battles. First, Verdun where combined French and German losses equaled

²⁵ Smith, 28-32.

²⁶ Weaver and Stewart, 1.

²⁷ Ibid., 1.

²⁸ Smith, 45.

²⁹ Ibid., 34.

³⁰ Ibid., 34.

roughly one million men. Second, the Somme, where British losses alone totaled some four hundred thousand men which “exceeded any losses they had previously experienced in the whole of their military history.”³¹ Like in the Civil War, during World War I artillery counted for a majority of combat casualties. Keegan articulately describes the horrendous scale of these bombardments at the Somme in 1916 vividly detailing the British massed fires against German positions which lasted some seven days or more and amounted to “about 1,500,000 shells” fired including howitzers, mortars, aerial torpedoes and gas.³² Death and destruction on this scale caused many soldiers to reach their breaking point.

Once again, authorities were faced with the dilemma of large numbers of psychological casualties from both the normal and disordered populations that Smith identifies in his research.³³ Psychiatrists began to focus on how individuals reacted to their fear. Typical symptoms of emotional reactions to fear include a sullen and pale look about the face, profuse sweating, palpitations and uncontrollable shaking.³⁴ Thus, physicians and psychiatrists again had a way to distinguish between those individuals who had “normal” physical reactions to fear and those who had no physical symptoms, but who nevertheless, succumbed to their fear and willfully failed at “exercising self-control” in order to continue the fight.³⁵ As in previous conflicts, the former type individual was seen as suffering from normal symptoms they couldn’t overcome. As a “result of occasion –the conditions of battle” and treated sympathetically; whereas, the latter was scorned as a coward and malingerer suffering from a predisposition resulting from “a defect of personal character.”³⁶ Needless to say, cowards and malingerers³⁷ received much harsher attention and those personnel who were seen to have been overcome by “occasion.”

³¹ Hans Binnevelde. *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry*. Translated by John O’Kane. Amsterdam: Amsterdam University Press. 1997, 31.

³² Keegan, 236.

³³ Smith, 34-36.

³⁴ Smith, 35.

³⁵ Ibid., 36.

³⁶ Ibid., 36.

³⁷ Ibid., 36.

In order to return troops to the fight as quickly as possible, psychiatrists used various treatment protocols. Which treatment used depended to a good extent on which of the aforementioned categories an individual was placed. Horowitz, Freud, and Smith all discuss the draconian measures used by nearly all parties to the conflict in returning cowards and malingerers to the front. Each country had its own name for the procedure; the French--“Torpillage”, the British--“quick cure” or “queen square methods” and the Germans--“Uberrumplungs methode”(“a surprise-attack method”).³⁸ Regardless of name, the procedures were essentially the same and involved the application of “extremely painful” electrical shocks to the patient.³⁹ These treatments were so unbearable that the individual would do anything to stop the torturous process--even return to the fighting.⁴⁰ Binneveld and Freud both note that this type of “punishment” oriented treatment fell into disrepute for obvious reasons.⁴¹

It is also during World War I that soldiers and later psychiatrists begin referring to a condition they called “shell-shock”.⁴² This newly recognized condition resulted from the “dazed disorganization which often followed in troops up-ended or buried in the explosion of artillery shells.”⁴³ The symptoms of “shell-shock” had all “the physical manifestations of organic injury” and rendered the sufferer incapable of continuing the fight.⁴⁴ Thus, in most cases, those suffering from “shell-shock” met with more acceptance.⁴⁵ However, it wasn’t long before an evolution in

³⁸ Mardi J. Horowitz. *Essential Papers on Posttraumatic Stress Disorder*. Edited by Mardi J. Horowitz. New York and London: New York University Press. 1999, 19.

Sigmund Freud. Introduction to Psycho-Analysis and the War Neuroses. In Mardi J. Horowitz (Editor), *Essential Papers on posttraumatic Stress Disorder*. New York and London: New York University Press. 1999, 103-105.

Smith, 49.

Binneveld, 107-116.

³⁹ Smith, 48-49.

⁴⁰ Binneveld, 108-109.

⁴¹ Freud, 103-105.

Binneveld, 107-116.

⁴² Smith, 37.

⁴³ Ibid., 37.

⁴⁴ Smith, 37-39.

⁴⁵ Ibid., 38.

thought occurred yet again and “shell-shock” was subdivided into cases resulting from physical injury—like damage due to blast overpressure—as “commotional disorder” and those hysterical disorders resulting from reactions to fear known as “emotional disorders”.⁴⁶ These labels quickly evolved into the later becoming “simply known as shell-shock” then still later known as traumatic neurosis; whereas, the former becoming known as “emotional shell-shock” and even later to become “hysterical neurosis”.⁴⁷ As one can see the pattern emerge, individuals suffering from traumatic neurosis were treated more compassionately, while the hysterical neurotics were seen as cowards and malingerers deserving of the harshest sanctions.⁴⁸

With a rise in Freud’s psychoanalytic theories, many physicians and psychiatrists began to apply those ideas to the treatment of the combat related neurosis. Freud speaks of there being a conflict within the Ego which attempts to protect the individual from the traumas associated with the war.⁴⁹ Similarly, Smith notes that psychiatrists “saw the individual caught in the conditions of war and torn between the impulse to flee and save himself and the desire to be brave and stand fast.”⁵⁰ Psychoanalytic treatments centered on Freud’s psychoanalytic techniques combined with hypnosis and suggestion in a calm setting “to give a patient insight into repressed traumatic experiences and psychological conflicts which took place in his subconscious.”⁵¹ This less draconian treatment was reserved for the traumatic neurosis patients and officers.⁵² The emphasis on Freud’s theories and the evolution of how the disorder was perceived led authorities full-circle with a heavy leaning towards predisposition.⁵³ Smith notes that this inclination toward predisposition had two disturbing unintended consequences; first, he states that much of the Officer Corps “were profoundly skeptical of the genuineness of many cases” and predisposition

⁴⁶ Smith, 41.

⁴⁷ Ibid., 41-46.

⁴⁸ Ibid., 46-48.

⁴⁹ Freud, 99-102.

⁵⁰ Smith, 53.

⁵¹ Binneveld, 116-120.

⁵² Binneveld, 119.

⁵³ Smith, 77.

theory merely re-enforced the officer's concerns while purporting that the cause was preexisting.⁵⁴ Secondly, since the disorder was deemed a result of a preexisting condition, individuals were left without recourse to make disability claims after the war.⁵⁵

World War II began, as World War I had ended, with the notion that predisposition was the "primary cause of combat breakdown."⁵⁶ With a new conflict, also came a new name for the war neurosis – "psychoneurosis" or "combat exhaustion."⁵⁷ All was not bleak, however, in several lessons carried over from World War I. One such lesson Smith describes is that psychological testing should be used to screen all draftees and volunteers for preexisting conditions which would render the individual susceptible to a breakdown as a result of combat stress.⁵⁸ Smith aptly points out though that an unintended consequence to this testing was it "resulted in the rejection of a vast number of individuals for military service" unnecessarily.⁵⁹ The other lesson learned was that treatment should be moved as close to the front as possible which should facilitate the rapid return to duty of anyone temporarily afflicted with combat exhaustion.⁶⁰ Of course, this too had unintended consequences in that, with the psychiatrists so close to the fighting themselves, they became more "sympathetic to the view that it was occasion—the conditions on the battlefield—which caused the reactions."⁶¹

This progressive and sympathetic approach to combat stress reactions did nothing to reduce the numbers of cases of "combat exhaustion"⁶² nor did this perspective change the views of many officers that cases of combat exhaustion were nothing more than cowards or malingerers.⁶³ Rather, high numbers of cases weren't seen by authorities as a product of occasion

⁵⁴ Smith, 59-77.

⁵⁵ Ibid., 79.

⁵⁶ Ibid., 80.

⁵⁷ Ibid., 80-88.

⁵⁸ Ibid., 80.

⁵⁹ Ibid., 81.

⁶⁰ Ibid., 85-86.

⁶¹ Ibid., 86-87

⁶² Ibid., 81-82.

⁶³ Ibid., 104.

as much “as failures of the screening system”.⁶⁴ Similarly, there was a widespread belief “that psychiatric casualties represented cowardice or poor motivation or weakness of character”.⁶⁵ General George S. Patton, Jr. typified the thoughts of many senior leaders and soldiers alike towards combat exhaustion casualties when he physically struck a soldier in a hospital in August 1943.⁶⁶ The soldier in question purportedly was a combat exhaustion casualty as by his own account could not continue to fight. General Patton was nearly relieved of command as a result of his actions –his removal arguably could have cost the Allies the war.

Smith notes that the theories and perspectives regarding combat stress reactions in the Korean conflict were nearly identical to those of World War II.⁶⁷ However, one fairly distinct legacy of the Korean War has come to light in a recently resurfaced and unattributed *New York Times* article entitled “*Former Prisoners of War Get Help in a Nashville Program.*” Prior to the U.S. Government acknowledging their issues in 1981, many of the just over 7,000 Korean War Prisoners of War (POWs) did not receive treatment for PTSD symptoms relating to their imprisonment. Rather, for some 30 odd years, these veterans had suffered nightmares, debilitating medical problems resulting from the brutal conditions they existed in during captivity and a host of mental health related syndromes.⁶⁸ Many lessons were learned from WW II and preparations from the beginning of the conflict included a return to “the front line treatment program with its principles of proximity, immediacy and expectancy with backup hospitals in the rear.”⁶⁹ Smith states that the one noticeable change appears to be that the Navy department “adopted the term combat fatigue” instead of exhaustion.⁷⁰

⁶⁴ Smith, 82.

⁶⁵ Ibid., 104.

⁶⁶ Ibid., 104.

⁶⁷ Ibid., 114.

⁶⁸ “Former Prisoners of War Get Help in a Nashville Program.” *New York Times*. December 8, 1987. Obtained from URL: <http://query.nytimes.com/gst/fullpage.html?res=9B0DEFD61E39F93BA35751C1A961948260>

⁶⁹ Smith, 114.

⁷⁰ Ibid., 116.

Understanding Post Traumatic Stress Disorder

All of the conventional wisdom about these disorders changed with Vietnam. As a result of numerous research studies to include the National Vietnam Veterans Readjustment Study (NVVRS) in 1983, we now have a base of knowledge concerning PTSD that transcends not just veterans, but victims of other trauma.⁷¹ In understanding the experiences of past veterans with PTSD, to include subsets within that general population, one can begin to make predictions regarding PTSD in veterans returning from service in operations supporting the Global War on Terror (GWOT) and the effect the disorder will have on our society as a whole. With a potentially grave problem looming, our military leadership, national leaders and society in general must develop an in depth understanding of PTSD and the effects that a high occurrence of this disorder in veterans will have on America in the coming decades. The first step is to develop a clear understanding of the problem we face; namely, an increasingly large percentage of veterans suffering from PTSD. Paramount to this endeavor is an in-depth knowledge of what exactly PTSD entails, including the recognizable signs and symptoms of the disorder.

Since the main body of knowledge about what we understand regarding PTSD comes from post-Vietnam research studies and in particular the 1983 NVVRS, in the review of existing knowledge this is where we begin in defining what constitutes PTSD. Kulka points out that the NVVRS used the criteria (or diagnostic requirements) of a diagnosis for full PTSD from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised*, or better known simply as the DSM-III-R. Additionally, Kulka discusses partial PTSD which represents those veterans that may have had full-blown PTSD, but don't know; however, these individual still have "clinically significant stress-reaction symptoms that could benefit from treatment."⁷²

⁷¹ Richard A. Kulka, Ph.D, et al. *Trauma and the Vietnam Generation: Report of Findings from the National Vietnam Veterans Readjustment Study*. New York: Brunner/Mazel. 1990, preface.

⁷² Kulka, et al., 59.

The DSM-III-R categorized PTSD under the general heading of Anxiety Disorders and then further defined the central element of the affliction as exhibiting “characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience.”⁷³ The DSM-III-R further states that whatever the event that results in an individual developing this disorder, it would be extremely disturbing and would evoke the same responses from nearly all people; this experience would be accompanied by “intense fear, terror, and helplessness.”⁷⁴ The broad symptoms associated with PTSD are an uncontrollable reliving of the event that caused the individual unbearable stress and trauma (in other words, flashbacks or involuntary replays of the event in their mind), blocking or attempts to block any activity or environmental condition or stimuli linked to the event or capable of causing the individual to experience negative reactions, an overall desensitization, deadening or mental paralysis and increased states of excitement or overall arousal.⁷⁵ The DSM-III-R identifies the following five general associated features as well: depression, anxiety, impulsive behavior (i.e. unexpectedly quitting a job, soliciting a prostitute or being absent without permission or letting family know what the individual’s plans are), organic mental disorder “such as failing memory, difficulty concentrating, emotional lability, headache and vertigo.”⁷⁶

These features outlined in the DSM-III-R are directly linked to two causes of PTSD, namely biological and psychological. As Dr. Mardi J. Horowitz explains, extreme emotional stressors trigger neurochemical changes in the human brain associated with the fight or flight response. The repeated exposure during combat to powerful hormones like corticosteroids, catecholamine and norepinephrine can produce physiological changes in the hippocampus and amygdale regions of the brain which alters the functions of “memory encoding” and the

⁷³ Robert L. Spitzer, M.D., (Chair), et al. *Diagnostic and Statistical Manual of Mental Disorders 3rd Edition-Revised*. American Psychiatric Association, Washington, D.C., 1987, 247.

⁷⁴ Ibid., 247.

⁷⁵ Ibid., 247-251.

⁷⁶ Ibid., 249.

“emotional–arousal–regulating” responses respectively.⁷⁷ Thus, these physical and chemical changes actually re-wire the way the veteran reasons and recalls memories. Moreover, Dr. Horowitz discusses that there are several theories regarding the psychological features or causes of PTSD including learned behavior, “shock mastery” and the “modification of cognitive maps” within the psyche.⁷⁸ Simply put, learned behavior involves the individual imprinting “strong new connections between bits of memory when experiencing a traumatic event” and the emotions and actions they associate with that stressor event – responses become ingrained in the psyche.⁷⁹ Stressor events can cause extremely realistic memories that “are so intense that they feel like a reliving of the traumatic experience” and when repeated, can cause extreme emotional shock.⁸⁰ Shock mastery then is when an individual learns to understand the memories and “the memory is adequately processed for personal meanings” – the problem arises when an individual continues to relive the event in their memories.⁸¹ Finally, Dr. Horowitz notes that in cognitive re-mapping, individuals can experience severe emotional distress as a result of the individual experiencing an event which elicits a response so counter to the person’s beliefs and norms that it skews how they think about themselves and their relation to the world.⁸²

Since Kulka’s research and the publication of the DSM-III-R, the American Psychiatric Association (APA) has updated the DSM which is now in its fourth edition and includes a text revision suitable for instruction. According to the APA, their intent in revising the diagnostic criteria in the DSM-III-R was to include all the body of recent research with the goal of enhancing the diagnostic capabilities of psychiatric and mental health professionals. To this end, McFarlane and Girolamo note that the APA has simplified the stressor criteria for PTSD in the

⁷⁷ Horowitz, 8-9.

⁷⁸ Ibid., 9-10.

⁷⁹ Ibid., 9.

⁸⁰ Ibid., 9.

⁸¹ Ibid., 9.

⁸² Ibid., 10.

DSM-IV-TR “proposing that such events should involve actual death or physical injury, or threat to the bodily integrity of oneself or other people”⁸³ and “the person’s response involved intense fear, helplessness, or horror.”⁸⁴ The remaining diagnostic criteria essentially follows that outlined in the DSM-III-R except that the DSM-IV-TR provides greater detail in the sub-categories of the criteria. Furthermore, the APA committee added the additional duration specifier of “Chronic” which is prescribed for use in those cases where the symptoms “last 3 months or longer.”⁸⁵ Moreover, as Bessel A. van der Kolk discusses, the APA’s DSM-IV Task Force undertook to include some of the newly identified symptomology out of recent research that caused victims discomfort yet that did not lend to a diagnosis of PTSD. These “core symptoms” were included “as tentative criteria for disorders of extreme stress not otherwise specified” (DESNOS) and included in the Associated Features and Disorders section of the DSM-IV-TR.⁸⁶

Many researchers, like Elizabeth A. Brett, do not see the efforts by the APA as a complete success though and offer some significant reasons for their position. Brett offers two primary reasons; first, she argues that PTSD continues to be categorized under anxiety disorders despite the fact that the PTSD advisory subcommittee “voted unanimously to place PTSD in a new stress response category.”⁸⁷ Similarly, the DSM-IV Task Force failed to adequately address the argument for inclusion of PTSD in the category of dissociative disorders.⁸⁸ This tension as to

⁸³ Alexander McFarlane and Giovanni De Girolamo. The Nature of Traumatic Stressors and Epidemiology of Posttraumatic Reactions. In Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp.129-154). New York/London: The Guilford Press. 2007, 134.

⁸⁴ Allen Frances, M.D. (Chair), et al. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. American Psychiatric Association, Arlington, VA. 2000., 467.

⁸⁵ *Ibid.*, 465.

⁸⁶ Bessel A. Van der Kolk. The Complexity of Adaptation to Trauma Self-Regulation, Stimulus Discrimination, and Characterological Development. In Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp.182-213). New York/London: The Guilford Press. 2007, 202-203.

⁸⁷ Elizabeth A. Brett. The Classification of Posttraumatic Stress Disorder. In Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp.129-154). New York/London: The Guilford Press. 2007, 117.

where to categorize PTSD stems because the symptomology crosses the boundaries of both anxiety and dissociative disorders.⁸⁹ Secondly, Brett argues that the Task Force overly restricted the “diagnostic criteria to essential features” only for PTSD; that is, including only the minimum criteria required for diagnostic purposes while neglecting “many characteristics of the disorder which have clinical and treatment relevance.”⁹⁰

Dr. Bridget Cantrell and Chuck Dean detail many of the characteristic symptoms associated with PTSD in their book designed to help returning veterans of the GWOT. Examination of several key symptoms is warranted when exploring a causal link between PTSD and criminal behavior. These key symptoms as Cantrell and Dean discusses are as follows:

- Cynicism and distrust of government and authority
- Anger
- Alienation
- Tendency to react under stress with survival tactics
- Psychic or emotional numbing
- Negative self image
- Poor concentration
- Memory impairment
- Emotional constriction
- Hypersensitivity to justice
- Loss of interest in work and activities
- Survivor guilt
- Difficulty with authority figures
- Hyper alertness hyper arousal
- Suicidal feelings and thoughts
- Flashbacks to dangers and combat
- Fantasies of retaliation and destruction
- High risk employment/recreation⁹¹

In comparison to the DSM-IV-TR, Cantrell and Dean’s list of symptoms goes beyond what is required for a diagnosis of PTSD by including symptoms to watch for that are not listed

⁸⁸ Ibid., 117.

⁸⁹ Brett, 121-124.

⁹⁰ Ibid., 125.

⁹¹ Bridget C. Cantrell, Ph.D and Chuck Dean. *Down Range: To Iraq and Back*. Seattle, Washington: Word Smith Publishing. 2005, 37-38.

by the APA – for example, “survivor’s guilt.”⁹² Cantrell and Dean do not deviate significantly from the APA guidelines; rather, they adhere to the spirit, if not the letter of the DSM-IV-TR. After all, Cantrell and Dean’s work is not intended for diagnosticians. A cursory examination of the key symptoms listed above quickly leads even the uneducated in the fields of psychology, psychiatry and criminal justice to see why many veterans would slip into a criminal lifestyle and have frequent confrontations with law enforcement agencies. Upon closer inspection of a few symptoms though and one can see clear links to PTSD symptoms and theories of criminal behavior discussed later in this work. For example, the symptoms of “anger” (or rage), “emotional constriction” (the bottling up of emotions until a breaking point is reached) and the “tendency to react under stress with survival tactics” (in other words, invariably this means to react with violence and aggression) are directly linked to Kenneth Dodge’s hostile attributional bias theory.⁹³

Furthermore, a thorough knowledge of the warning signs of PTSD is critical to identifying those who are at risk in an organization. As each individual is different and has different thresholds of symptomology or coping skill, the warning signs discussed will all be present or only a few may be present. Cantrell and Dean identify seven key warning signs to be aware of when identifying at-risk individuals and assisting them to seek treatment or manage their reaction to stressors. First, sufferers of stress disorders frequently complain of chronic exhaustion and may appear to lack the energy to complete even the simplest of tasks. Next, many veterans describe an inability to stay focused, to keep on track with a task – simply put, their mind wanders and they cannot concentrate. Many veterans complain of being unable to

⁹² Ibid., 37-38.

⁹³ Curt R. Bartol and Anne M. Bartol. *Criminal Behavior: A Psychosocial Approach*, 7th Edition. Upper Saddle River, New Jersey: Prentice Hall. 2005, 252-254.

control their emotions and they report being extremely disturbed by a propensity to get irritated at the slightest issue or problem. Changes in personal habits such as hygiene and personal appearance or sleep patterns and eating – basically PTSD sufferers simply start to not care and cease taking care of themselves. As discussed earlier, individuals develop “feelings of depression, guilt, anxiety and helplessness” and these emotions now become manifest to those closest to the veteran.⁹⁴ Veterans’ physiological health may become damaged as the effects of prolonged stress take its toll on their bodies. Many veterans complain of “prolonged tension headaches, lower backaches, stomach problems or other physical problems” which will increasingly manifest themselves causing more absenteeism and appointments for medical attention.⁹⁵ Finally, all of the aforementioned warning signs may coincide with a veteran’s attempt to self medicate; that is, use alcohol or illicit drugs in order to counteract the other problems they are experiencing and this may inevitably lead to substance abuse.

It is important to note that all of the symptoms associated with PTSD may either manifest themselves immediately in soldiers or may not begin to manifest themselves for quite some time, causing veterans to show signs of the syndrome from between three and four months after return from the combat zone. Moreover, the syndrome may not manifest itself until years later as a result of a stressful event that reminds the veteran of some wartime traumatic event.⁹⁶ Cheryl A. Roberts notes that even after half a century has passed, more than half of the survivors of Hitler’s genocidal policies to eradicate the Jews from Europe still show signs of PTSD and some have just begun to show outward manifestations of the syndrome.⁹⁷

⁹⁴ Cantrell and Dean, 50.

⁹⁵ Ibid., 50.

⁹⁶ Ibid., 71.

⁹⁷ Cheryl A. Roberts. *Coping with Post-Traumatic Stress Disorder: A Guide for Families*. McFarland & Company, Inc. Jefferson, North Carolina., 2003, 24.

Equally important is that Cantrell and Dean identify that PTSD is not only found in the personnel engaged in close-quarters combat; rather in Vietnam, as well as in Iraq and Afghanistan, with combat related stressors all around the theatre of operations (irregular warfare, where there is no forward edge of the battle and no safe rear echelon area) and Improvised Explosive Devices (IEDs), suicide bombers and indirect fire all being special stressors, any soldier is subject to developing PTSD.⁹⁸ Moreover, Hicks and Petersen explain that there are several levels of combat related stress that an individual may experience. The “levels of exposure to combat stress” that Hicks and Petersen identify are “high exposure,” “medium exposure” and “low exposure.”⁹⁹ As defined, the highest level of exposure entails actual close-quarters combat or direct combat, the middle level entails direct combat to “near combat” and the lowest level involves being in the combat zone, yet still subject to attack and in imminent danger.¹⁰⁰

Vietnam Experience and Parallels with the GWOT

With an understanding of what PTSD includes as a syndrome, it is now important to attempt to understand how and why soldiers have come to be plagued by such a serious and potentially debilitating disorder. In order to fully appreciate what causes PTSD, one must examine the nature of war; specifically it is essential to compare and contrast the Vietnam experience with that of the current campaigns of the GWOT.

It has already been established that the vast majority of what is now known about PTSD comes from the Vietnam War experience. Additionally, it has been stated that all wars are violent affairs and brutal. The fact that acts of brutality occurred in Vietnam is one of the strongest similarities between the Vietnam War and other wars. The brutality became almost institutionalized in the Vietnam War. Rather than having a few isolated incidents of atrocities (as

⁹⁸ Cantrell and Dean, 36.

⁹⁹ Robert M. Hicks. and Randy Petersen. *Returning Home: Practical Advice for War Veterans, Their Families and Friends*. Fleming H. Revell Co. Tarrytown, New York, 1991, 66.

¹⁰⁰ Ibid., 66.

had been the case in other wars), what happened in Vietnam was, as the noted law authority and military consultant Richard A. Falk has stated that "...the overall conduct of the war" and "the general line of official policy established a moral climate in which the welfare of Vietnamese civilians is totally disregarded."¹⁰¹ One can try to understand why the American soldiers would act callously and with a disregard for the Vietnamese people, after all, the soldiers did not know who their enemy was and because of this, the soldiers felt as Jack McClosky-a former Marine medic-has stated:

"Your basic mistrust of the Vietnamese people is already engrained in you; anything with slant eyes was a "gook-they were not human beings."¹⁰²

By the very nature of the insurgency, the American soldiers would become conditioned by fighting an elusive enemy day after day and watching as their comrades and friends died, that the people they were in Vietnam to protect were actually aiding the enemy. The soldiers would get to the point where they lost sight of their humanity and would commit brutal acts out of frustration. James Farmer is a veteran and was a Specialist (SPC) in the United States Army during November of 1969. The comment that Mr. Farmer made during the same time,- specifically on 29 November 1969-that, "The only good Dink is a dead Dink," more than illustrates how many of the Americans in Vietnam felt towards the Vietnamese people and opens a window into the minds of those same veterans as to how callous they had become overall.¹⁰³

As an example of the devastation veterans witnessed in Vietnam, during the heaviest fighting, a policy that developed was that of establishing areas designated as Free Fire Zones. These zones were designed as such to "break the link between the insurgents and the general population."¹⁰⁴ In short, from a soldier's perspective, Free Fire Zones meant "you could shoot

¹⁰¹ Michael Maclear. *The Ten Thousand Day War: Vietnam, 1945-1975*. St Martin's Press, New York., 1981, 275.

¹⁰² Maclear, 276.

¹⁰³ William G. Effros. *Quotations Vietnam: 1945-1970*, Random House, New York, 1970, 155.

¹⁰⁴ Edward Doyle and Stephen Weiss, et al. (1984). *The Vietnam Experience: A Collision of Cultures*. Boston, Boston Publishing Co., 1984, 139.

any and all people that you found. They were enemy or they had no business being up there.”¹⁰⁵

The use of available firepower in Vietnam was unbelievable. Doyle and Weiss point out that “American commanders at all levels in Vietnam had at their disposal conventional weapons of every conceivable kind in almost unlimited amounts.”¹⁰⁶ This overwhelming employment of force combined with “the inadequacies of intelligence, over reaction, and even indifference led to a considerable destruction of property and a large number of civilian casualties.”¹⁰⁷ Devastation on a grand scale, countless-even nearly institutionalized-brutal atrocities, fighting an elusive enemy all while support dwindled at home took a toll on the Vietnam veterans. To add insult to injury, many veterans were vilified upon returning to their homes.

To further understand why this war had such a profound negative effect on its veterans, one must understand who these men and women were. Most, nearly 75 percent of those men who are included in the Vietnam era veterans were married compared with around half of the women.¹⁰⁸ Approximately 34 percent of those serving in Vietnam had High School educations (just under the overall US average for 1987) with “an additional 40 percent had some college education.”¹⁰⁹ Racially, those who served were nearly 87 percent Caucasian, 11 percent African American and roughly 5 percent Hispanic-very similar to the US population as a whole in 1986.¹¹⁰ In a surprise to the myth that most Vietnam veterans were draftees, Kulka points out that most Soldiers were volunteers with just “over 25 percent were drafted.” Only 1 in 5 Soldiers served more than 1, one-year tour and roughly 30 percent being in combat for less time than the standard year.¹¹¹

¹⁰⁵ Ibid., 139.

¹⁰⁶ Doyle and Weiss, 126.

¹⁰⁷ Doyle and Weiss, 136.

¹⁰⁸ Kulka, et al., 27.

¹⁰⁹ Ibid., 27.

¹¹⁰ Ibid., 22.

¹¹¹ Ibid., 23.

To summarize, the typical Vietnam veteran nearly mirrors the typical American of the period and confirmed using census data from 1986. These individuals experienced some of the most violent and frustrating aspects of an unpopular war. Veterans from Vietnam suffered guilt about their experiences in higher amounts than veterans of previous wars due to the barbaric acts committed and the feeling that the war was unjustified, to the extent that the suicide rate for these veterans is “23 percent higher than non-veterans of the same age.”¹¹² Additionally, Hendrin points out that substance abuse remains a major problem confronting many Vietnam veterans.¹¹³

This wartime experience has produced some of the highest rates of PTSD ever examined in veterans; however, the actual percentages from past wars may never be known because the diagnostic tools required to make an accurate accounting have only been available since the Vietnam War and many of the veterans from wars past and any knowledge they may have had is lost to researchers as those veterans have died. Research shows that approximately 54 percent of all male combat veterans of Vietnam have “experienced clinically significant stress-reaction symptoms” throughout their lifetimes.¹¹⁴ Furthermore, some 15 percent of males and 8.5 percent of female veterans were found to have chronic symptoms of PTSD at the time of the NVVRS in 1983 and an additional 11 percent males and just over 7 percent of female veterans were found to have “partial PTSD” or “trauma related symptoms that may benefit from professional treatment.”¹¹⁵

By way of comparison, the experience in the campaigns of the GWOT (specifically, in Iraq and Afghanistan) are not that dissimilar from that of Vietnam and yet there are striking differences which may have a significant role in lower incidences of PTSD in returning veterans.

¹¹² Kulka, et al., 160-161.

¹¹³ Hendrin, 183-184.

¹¹⁴ Kulka, et al., 53.

¹¹⁵ Ibid., 52-53.

The nature of the warfare in both Iraq and Afghanistan are similar to Vietnam in that it is guerilla warfare or an insurgency; although, as of recent, the conditions in Iraq are arguably looking more and more like a civil war. The Islamic insurgents in both areas are equally elusive as the Viet Cong were in Vietnam, they are equally brutal and the violence they perpetrate is as frustrating to current soldiers as the Viet Cong's tactics were to Vietnam era veterans. The level of indiscriminate violence that U.S. personnel participate in is greatly diminished as our forces now strive for precision in the application of the use of force. However, the level of senseless sectarian violence our soldiers witness and are helpless to stop rivals any barbarism committed in Vietnam. The guerilla tactics employed by the Islamic terrorists are quite frightening and the fact that it is indiscriminate leaves soldiers wondering when, where and how they will get killed. With this constant threat, of being in the wrong place at the wrong time, soldiers are always vigilant for threats.¹¹⁶

Moreover, as Hicks and Petersen discuss, we as soldiers today are expected to act with a character along the lines of the so-called warrior monk.¹¹⁷ We aspire to have no vices and adhere to a core set of values set higher than the general public. For example, General Order Number One in theatre prohibits alcohol, drugs and nearly bans sex – these prohibitions are two-fold, keep the warrior monks acting like monks and also to avoid straining the sensibilities of our Muslim allies. Most soldiers wrestle with the hardships of being in a nasty environment, away from family and friends all while expected to act like Boy Scouts. It can add quite a lot to all the combat related stressors. These high expectations we have set for our warriors can act to inhibit soldiers from seeking help as that may expose a flaw in their armor. Moreover, in our modern age, even the avenues we choose to “relax” can compound the problem – many soldiers, of all ages, return to their quarters to play countless hours of violent video games in an attempt to

¹¹⁶ Brett T. Litz. *A Brief Primer on the Mental Health Impact of the Wars in Afghanistan and Iraq*. A National Center for PTSD Fact Sheet. US Department of Veterans Affairs. Retrieved 11 August 2007 from URL: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_iraq_afghanistan_lay_audien.html

“relax.” The cycle can be maddening, conduct combat patrols, play violent video games and repeat.

As stated, there are differences between the two conflicts. Whereas Vietnam was seen as a misadventure, the GWOT is seen as a response to an attack on America and ongoing operations to eradicate Islamic terrorists who target Western society. Subsequently, most soldiers do not feel the same sense of guilt that Vietnam veterans did and GWOT veterans are not vilified like their Vietnam War counterparts. Today, our whole force is comprised of volunteers with just over 72 percent of the veterans being Caucasian, right at 17 percent of the force is African American and a little more than 10 percent are of Hispanic origin. Fewer soldiers are married today than during Vietnam with just over 51 percent of soldiers married. Our all volunteer force consists of nearly 78 percent High School graduates, a little over 11 percent have a bachelor’s degree (either AB/BS), 3 percent have a graduate degree and 1% have PhD’s. Females in the combat zone have increased to 11 percent now up from the Vietnam War’s 7 percent.¹¹⁸

Disturbingly, however, more soldiers are spending greater amounts of time in the combat zones due to the current rotation policy. In Vietnam, soldier’s rotated into and out of theatre individually in contrast to the World Wars and Korea where the policy was to deploy organic units which fostered unit cohesion, a sense of shared adversity, strong bonds and supportive empathetic peers providing inherent protective factors against PTSD. Moreover, units rotated back to the United States together over a greater period of time on boats rather than rapidly by aircraft in just a few days. Some lessons have been learned whereas now, soldiers rotate as units with one quarter of theatre GWOT veterans deployed more than once on a one year tour of

¹¹⁷ Hicks and Petersen, 61.

¹¹⁸ Michelle Tan. By the Numbers: Who’s Fighting. *The Army Times*. A Gannet Newspaper. Retrieved on 10 December 2006 from URL: <http://www.armytimes.com/story.php?f=1-292925-2395712.php>.

duty.¹¹⁹ Thus far, the prevalence of PTSD in returning GWOT veterans is over 17 percent for the Iraq campaign and just over 11 percent for those returning from the Afghanistan campaign.¹²⁰

Theories on a Causal Link Between PTSD and Criminal Behavior

Now that there is an understanding of what PTSD consists of in the way of a disorder and we understand why modern warfare can produce a high prevalence of the syndrome, we can examine what may precipitate the transformation of a veteran into a criminal. The National Center for PTSD offers that the syndrome can be related to the conduct of crimes via two links. One major hypothetical linkage is that the very symptoms of the syndrome predispose the veteran to commit crimes. Additionally, the crimes veterans commit may be a recreation of a traumatic event the veteran remembers or may feel guilty about having participated.¹²¹ Baker also offers the example of a veteran named Mr. Gregory to illustrate the recreation of a traumatic stressor. In Vietnam, Mr. Gregory was in an ambush that wiped out nearly all his unit. Several years after returning from the combat zone, he stormed into a bank in “an attempt at passive suicide.”¹²²

Although the National Center for PTSD offers these two theories as potential causal links and there is no doubt that many more would apply, the three that best explain the plausible causal link between criminal behavior and PTSD are; hostile attributional bias, frustration-aggression theory and impulsive violence theory. Bartol discusses Kenneth Dodge’s hostile attributional bias as a reason why individuals act out violently. Dodge posits that individuals who are already predisposed to violence will resort to violent solutions to perceived injustices or any issue which may frustrate them.¹²³ The symptoms of PTSD have been shown to predispose veterans to act

¹¹⁹ Tan, (website, no page numbers).

¹²⁰ Hoge, (website, no page numbers).

¹²¹ Claudia Baker, MSW, MPH and Cessie Alfonso, LCSW. *PTSD and Criminal Behavior*, A National Center for PTSD Fact Sheet. US Department of Veterans Affairs. Retrieved 11 August 2007 from URL: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_legal.html?opm=1&rr=rr91&srt=d&echorr=true 2006.

¹²² Ibid., (website, no page numbers).

¹²³ Bartol 2005, 252-254.

out violently and the veteran may mistake an individual's intent as violent, destructive or threatening to them causing an inappropriate response. Hendrin notes that 40 percent of veterans who show symptoms of PTSD have committed crimes in the period after their wartime service and that, in fact, the overall most prevalent criminal behavior was violent crimes.¹²⁴

Similarly, though as Bartol points out, an individual who may be experiencing frustration with their situation doesn't mean that they will act violently or aggressively; however, Leonard Berkowitz's frustration-aggression theory may explain why a high percentage of veterans with PTSD commit crimes. The frustration-aggression theory holds that when an individual is prevented from attaining an objective or filling some need, they may become frustrated and thus infuriated which can cause them to be susceptible to aggression and violent outbursts. Since veteran's suffering from PTSD are already predisposed to reverting to coping skills honed in combat they will be more likely to act out violently.¹²⁵

Finally, and most probably, as Bartol relates, Hans Toch and others theorize that crime is a result of a tendency of some individuals to act impulsively and commit acts with little to no forethought.¹²⁶ Cheryl Roberts posits that individuals become conditioned to operate effectively even under traumatic circumstances and that the skills developed to survive such times and events become the norm and are difficult to abandon.¹²⁷ The fact that some 40 percent of veterans surveyed as part of the NVVRS recounted that they had been involved "in violent acts 3 or more times in the preceding year" seems to support the theory that veterans have developed violent coping skills and continue to use those skills, albeit inappropriately.¹²⁸ Soldiers often remark euphemistically that there is no problem in life that can't be solved with the proper application of force – subconsciously some veterans may really believe what they are saying.

¹²⁴ Hendrin, 134.

¹²⁵ Bartol 2005, 244-247.

¹²⁶ Bartol 2005, 354-355.

¹²⁷ Roberts 2003, 18.

PTSD is no longer thought to be a taboo syndrome; rather, as Hicks states “the most important thing to remember about post-traumatic response is this: it is normal. It is normal to respond in abnormal ways to abnormal circumstances.”¹²⁹ Getting the veterans the help they need before they are returned to the community is paramount to the Department of Defense (DoD) and our national leaders. The current DoD policy attempts to reduce the incidence of PTSD through the rotation policy. That is, through a policy of unit rotations vice individual replacements. As Shay contends, one of the most effective ways for the military to prevent or reduce the incidence of permanent stress-disorders on soldiers is to maintain a policy of unit rotations. Shay theorizes that there is a lower incidence of PTSD in veterans from other wars because of the policy which saw that “soldiers trained together, went overseas together, fought together, had R&R together and came home together.”¹³⁰ Such was not the case with Vietnam veterans. Moreover, the DoD has deployed hundreds of mental health professionals to theatre to assist soldiers before they ever return home.

Additionally, the DoD has programs in place at each military installation to screen returning personnel for signs of PTSD. The veterans are also encouraged to take advantage of anonymous Veteran’s Administration (VA) screening programs if they feel too embarrassed or apprehensive about openly seeking help. Of course, there are always provisions to involuntarily refer a soldier if his chain of command feels it is warranted. Finally, the DoD and VA have set aside resources for the treatment of those personnel diagnosed with PTSD as a result of the GWOT. Currently, the DoD and VA have sanctioned several approaches for treatment of PTSD

¹²⁸ Jonathan Shay, M.D., Ph.D. *Achilles in Vietnam: Combat Trauma and the Undoing of Character*. New York: Scribner. 1994, 195.

¹²⁹ Hicks and Petersen, 53.

¹³⁰ Shay, 198.

which are subdivided under the two broad categories of pharmacotherapy and psychotherapy “interventions.”¹³¹ Medication interventions are used to alleviate “the physical, psychological and behavioral morbidity” common in PTSD and bring about rapid recovery in patients. The use of medications is not indicated in all cases and the efficacy of such treatment remains mixed. There is empirical data which suggests psychotherapy shows significant benefit in treatment of PTSD.¹³² The psychotherapy treatments include the following:

- Cognitive Therapy
- Exposure Therapy
- Stress Inoculation Training
- Eye Movement Desensitization and Reprocessing
- Imagery Rehearsal Therapy
- Psychodynamic Therapy
- PTSD Patient Education
- Dialectical Behavioral Therapy
- Hypnosis¹³³

After careful examination of all the aforementioned evidence about the prevalence of PTSD in Vietnam veterans and the statistics already tabulated regarding the incidence of PTSD in veterans returning from the GWOT one can see where the nation may be facing a new upsurge in crime perpetrated by returning veterans. Though some predict that the unit rotation policy will lower the prevalence of PTSD in returning veterans, the final verdict is still pending. As Cantrell contemplates, multiple rotations and extended tours have long term implications for our young service people and their family members.”¹³⁴ If the statistics from 1978 concerning Vietnam veterans hold true for similar statistics of GWOT veterans, we could have a problem for our

¹³¹ VA/DoD *Clinical Practice Guideline For The Management of Post Traumatic Stress: Interventions Module Summary*. December 2003. Retrieved from URL: http://www.oqp.med.va.gov/cpg/PTSD/G/Interv_Sum508.pdf, 7.

¹³² VA/DoD, 9.

¹³³ VA/DoD, p.7.

¹³⁴ Cantrell and Dean, 34.

country that will not have any easy solutions. In 1978, some 29,000 Vietnam veterans were incarcerated with another 37,000 on parole, 250,000 veterans under mandatory supervision and 87,000 awaiting trial.¹³⁵

CHAPTER TWO

REVIEW OF THE RESEARCH DATA

Collins and Bailey's survey population was 1327 male felon inmates in the North Carolina correctional system. Of the 1327, n (inmates who participated) =1140 while 135 (10%) refused to participate, thirty-five (just under 3%) failed to take part in the survey because they transferred to another facility prior to their interview, eight (or just under 1%) were disqualified because of physical and/or mental deficiencies or a language impediment and nine (just under 1%) "were dropped due to erroneous interviews or inconsistent data."¹³⁶ The researchers found that twenty-six inmates met the diagnostic criteria under the DSM-III for PTSD (or just over 2%), while n=795 (or some 70%) answered positively indicating they had at least "one or more symptoms" of PTSD.¹³⁷ The respondents (54% of those diagnosed with PTSD and 6% of those without PTSD) answered that the most prevalent "precipitating traumatic event" or stressor, was either witnessing another person being harmed and/or killed. The second most prevalent stressor for those with PTSD (n=8 or 31%) was combat while "less than 1% of those" (n=10) without a diagnosis of PTSD responded positively to having seen combat duty.¹³⁸ Collins and Bailey looked at two forms of violence for incarcerating offense; "expressive" or "emotional" violent acts (which includes "homicide, rape, or aggravated assault") and "instrumental" or "acquisitive"

¹³⁵ Hendrin, 133.

¹³⁶ Collins and Bailey, 206.

¹³⁷ Ibid., 208.

violent acts (burglary).¹³⁹ Their findings were that for the current incarcerating offense, fourteen percent (n=160) were imprisoned for an expressive violence charge, whereas twelve percent (n=137) were convicted and imprisoned for instrumental violence charges. Moreover, Collins and Bailey screened the inmates for their lifetime criminal history (“at least one lifetime arrest”) and found that thirty-one percent (n=353) were convicted and imprisoned for acts of expressive violence and just under seventeen percent (n=192) were imprisoned for acts of instrumental violence.¹⁴⁰ Overall, of their sample population, Collins and Bailey report that twenty-five percent (n=285) answered positively to having one symptom or more.¹⁴¹

The results also indicate that “individuals with PTSD diagnoses are 6.75 times more likely than those without such a diagnosis to have been arrested for a violent offense in the year before their imprisonment.”¹⁴² Additionally, their evidence shows that individuals with bonafide PTSD are 4.58 times more likely to be currently imprisoned for an expressive violent act.¹⁴³ Another critical finding demonstrates that for the subjects who answered positively for at least one PTSD symptom and who also were charged with one or more expressive violent act, “85% reported their first PTSD symptom in the same year as the arrest for homicide, rape, or assault or in a preceding year.”¹⁴⁴ On the other hand, Collins and Bailey show that fifteen percent of their subjects reported that their arrest occurred before they became symptomatic for PTSD.¹⁴⁵

Finally, Collins and Bailey discuss how the results of their research indicates a significant link between PTSD and the commission of violent criminal acts and that their data “is consistent

¹³⁸ Ibid., 211.

¹³⁹ Ibid., 210.

¹⁴⁰ Collins and Bailey, 210.

¹⁴¹ Ibid., 212.

¹⁴² Ibid., 215.

¹⁴³ Ibid., 215.

¹⁴⁴ Ibid., 216.

¹⁴⁵ Ibid., 217.

with previous findings that PTSD symptoms preceded or occurred at the same time as violent behavior.”¹⁴⁶

The BJS has been conducting surveys of incarcerated veterans in prison and jails since 1986 and compiling data on active-duty personnel confined in military prisons since 1997. According to the BJS in a special report from January 2000, in 1986, 24.9% of Federal inmates and 20.2% of State inmates surveyed reported military service. In 1983, some 21% of prisoners in local jails reported having served in the military. However, by 1997, veterans accounted for just over 14% of inmates in Federal facilities and some 13% of State inmates stated they were veterans. Data for local jails is available for 1996 whereby 11.7% reportedly were veterans. For Federal incarcerations, this represents a 10.9% decrease in veterans over a 14 year period. During the same time, the number of veterans held in State institutions dropped by 7.2%. By 1996, veterans held in local jails declined by 9.3% down from 1983 numbers. BJS reports that although the percentages of veterans in prisons or jails have decreased between 1986 and 1997, this is due to an overall 172% increase in incarcerations throughout America which statistically shows a corresponding decrease in the veteran inmate populations in relation to non-veteran inmates. In reality, veterans “in prisons or jail rose from 154,600 in 1985 to 225,700 in 1998, an overall increase of 46%.”¹⁴⁷ This would account for an influx of veteran inmates due to the Gulf War (first Iraq war, 1991).

Table #1 below, from the 1997 BJS data, shows that nearly equal percentages of incarcerated veterans served during conflict as well as peacetime; however, BJS reports that 20% of both Federal and State incarcerated veterans and 21% of those in local jails stated they had been in combat during their military service.¹⁴⁸ Data shows that Vietnam veterans in 1997 (35%

¹⁴⁶ Ibid., 216.

¹⁴⁷ Christopher J. Mumola. *Veterans in Prisons or Jails*. Bureau of Justice Statistics Special Report No. NCJ178888. U.S. Department of Justice, Office of Justice Programs. Washington D.C. Retrieved from URL: <http://www.ojp.usdoj.gov/bjs/>, 2000, 1.

¹⁴⁸ Ibid., 3.

imprisoned in State facilities and 43% in Federal institutions) remain the largest percentage of incarcerated veterans. As noted above, while all other percentages of veteran inmates from previous conflicts continued to decrease, veterans of the Gulf War displayed a marked increase in confinements immediately following the hostilities until 1997 becoming the second largest veteran demographic represented in Federal and State institutions.¹⁴⁹

	Percent of veterans in prison			
	State		Federal	
	1997	1991	1997	1991
Time of military service*				
Peacetime	50.3%	50.9%	39.0%	37.1%
Wartime	49.7	49.1	61.0	62.9
World War II era (1941-45)	1.3	1.4	1.2	4.5
Korean Conflict era (1950-53)	2.9	5.7	4.6	8.8
Vietnam War era (1964-1973)	35.3	42.1	43.3	49.0
Persian Gulf War era (1990-1991)	11.7	1.3	12.9	1.6

*Veterans may have served during more than one period of wartime.

*Table #1*¹⁵⁰

Regarding prior criminal histories, 40% of veterans reporting having served in combat had no history, whereas veterans who saw no combat during their service (27%) had no prior criminal history.¹⁵¹ Finally, over half (55%) of veterans imprisoned in State correctional facilities and 22% of veterans held in Federal institutions were serving sentences for committing violent acts (both expressive and instrumental violence).¹⁵²

The BJS published a second report (May, 2007) on the status of veterans in prisons and jails for 2004. The report shows that the number of veterans in prisons and jails remained high until 2000 (no significant change to aforementioned data from 1997); however, according to BJS

¹⁴⁹ Ibid., 3.

¹⁵⁰ Mumola, 3. This table was recreated from the original report.

¹⁵¹ Ibid., 7.

¹⁵² Ibid., 5.

data for 2004, between 2000 and 2004 “the number of veterans in prison fell by 13,100 or 9%.”¹⁵³

This is inconsistent with the theory that veteran incarcerations should have increased during this time period due to the GWOT. The report explains that part of the reason for the declining numbers of incarcerated veterans directly relates to the overall “declining numbers of veterans in the U.S. resident population.”¹⁵⁴ BJS cites that from 1985 veterans decreased to 11% “of the adult U.S. resident population.”¹⁵⁵ Moreover, as the number of personnel on active-duty decreased over the same time period (a 34% decline), this attrition also contributes to the overall decline of veterans in the U.S.¹⁵⁶ Clearly, however, attrition in the number of incarcerated veterans would continue as a result of paroles, releases (completion of sentence), executions or death in prison due to natural causes or foul-play.

In 2004, more veteran inmates reported having served during wartime (65% Federal and 54% State institutions) than in 1997 reflecting a 4% and 4.5% increase respectively. Vietnam veterans remained the largest represented group of veterans while Gulf War veterans increased 2.3% in State facilities and 8% in Federal institutions. Additionally, veterans from the Afghanistan and Iraq campaigns (GWOT) now represent 3.7% of veterans in State facilities and 4.5% in Federal institutions.¹⁵⁷ Regarding combat, from 1997 to 2004 the percentage of veterans having served in combat saw no appreciable change overall (21% and 20% respectively); whereas, some 25% of Federal inmates reported in 2004 that they had served in combat reflecting a 4% increase from 1997.¹⁵⁸ This increase would be consistent with more personnel participating in combat during the GWOT. As in 1997, veteran inmates were more likely than non-veterans to

¹⁵³ Margaret E. Noonan and Christopher J. Mumola. *Veterans in State and Federal Prison, 2004*. Bureau of Justice Statistics Special Report (NCJ217199). U.S. Department of Justice, Office of Justice Programs. Washington D.C. Retrieved from URL: <http://www.ojp.usdoj.gov/bjs/> , 2007, 2.

¹⁵⁴ Ibid., 2.

¹⁵⁵ Ibid., 2.

¹⁵⁶ Noonan and Mumola, 2.

¹⁵⁷ Ibid., 9.

¹⁵⁸ Ibid., 3.

have “shorter criminal records” or no prior history.¹⁵⁹ Also in 2004, the report notes that veteran perpetrated violent offenses (both expressive and instrumental violence) remained stable from 1997 with 57% in State facilities and 19% in Federal institutions.¹⁶⁰

The 2004 special report also looked at the mental health histories of incarcerated veterans. Veterans in State institutions (54%) reported “any mental health problem,” 30% reported a “recent history of mental health services” within the “year before arrest or at any time since admission” to the facility and 45% reported “symptoms of mental health disorders” within “12 months prior to interview.”¹⁶¹ For veterans responding to the same mental health questions in Federal custody, the response was 43% for “any mental health problem,” 21% for “recent history” and 35% for “symptoms.”¹⁶² These findings represent a significant number of veterans in confinement suffering from serious behavior issues and may be consistent with undiagnosed PTSD.

Incarceration data for all DoD prisoners was available and examined for the following years: 1997, 1998 and years 2002 thru 2006. Although overall total numbers of DoD prisoners decreased from 1997 (n=2756) to 2003 (n=2165), the percentages of military inmates confined for violent criminal offenses (both expressive and instrumental violence) remained high Table #2 shows rates of consistently $\geq 40\%$ with the exception of 2002 (37%) and 2005 (39%) for the period. The percentages for these two years (2002, 2005) remain significantly high. Between 2003 (the beginning of the GWOT Iraq campaign) and 2005, DoD military incarcerations increased 7.25% while the percentages of inmates confined for violent offenses has remained stable at $\geq 39\%$ per year while showing an overall increase of 5.44%. However, from 2005 to 2006, total DoD incarcerations dropped by 378 inmates or 19% while the overall percentages for

¹⁵⁹ Ibid., 1.

¹⁶⁰ Ibid., 11.

¹⁶¹ Noonan and Mumola, 15.

¹⁶² Ibid., 15.

those personnel confined for violent offenses rose 4% (n=845) or 43% of the total population – a six year high.

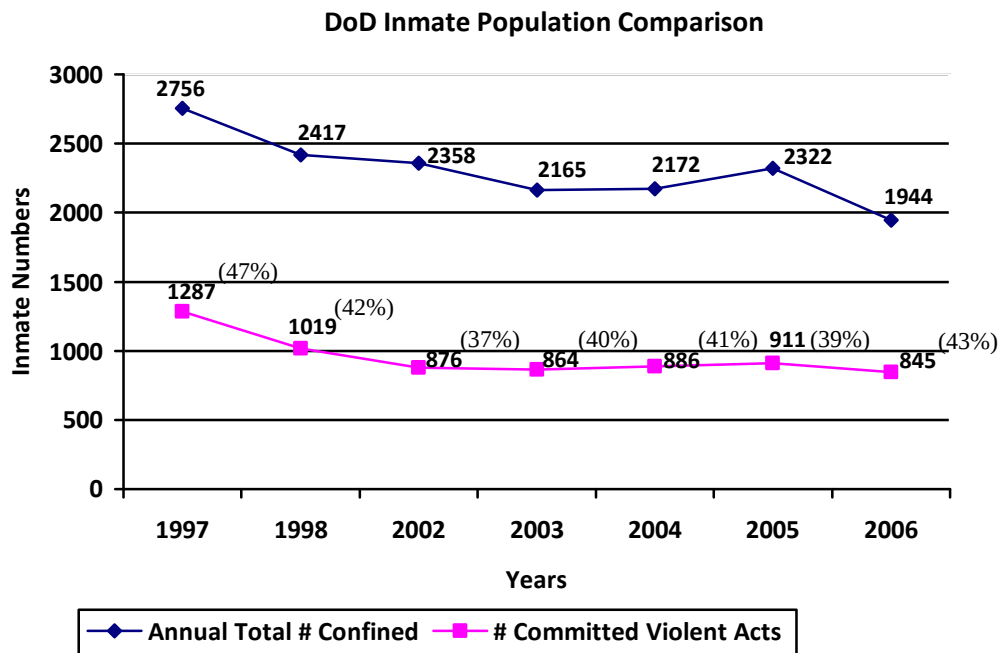


Table #2

The fact that the total number of inmates has dropped does not necessarily reflect a disputation of the correlation between PTSD and criminal behavior. Rather, part of the reason for the overall decline in military prisoners is due to DoD policy (established by agreement with the Bureau of Prisons in 1994)¹⁶³ that allows the annual transfer of military prisoners to the Federal Bureau of Prisons (FBOP). During the period from 1997 until 2006, DoD transferred roughly 697 inmates. This is not a malicious attempt on the part of DoD to dump inmates into the already overburdened national correctional system; rather, the inmates transferred are usually those military personnel whose sentence has been completely adjudicated to include their discharge or prisoners are transferred to medical prisons to receive special medical attention. These transfers may, however shift the burden of treatment for PTSD on to the States and Federal Governments.

¹⁶³ David K. Haasenritter. *The Military Correctional System: An Overview*. Retrieved from URL: <http://www.aca.org/publications/ctarchivespdf/dec03/haasenritter.pdf> , 3.

Moreover, because the Uniform Code of Military Justice (UCMJ) affords commanders the flexibility to courts-martial a service member for criminal activities or remove an individual for misconduct and various other reasons under the provisions of Army Regulation (AR) 635-200, *Active Duty Enlisted Administrative Separations*, many soldiers are simply “chaptered” or removed from the Army rather than being courts-martialed and incarcerated. Indeed, commanders must consider matters of extenuation and mitigation when deciding which avenue to pursue regarding adjudicating soldier misconduct and many consider not only performance, but also exposure to trauma when making their decision. Regardless, with an increase in the number of soldiers misbehaving and a high operations tempo, many commanders elect to remove personnel who have become criminals from their ranks the most expeditious way – through the procedures of AR 635-200.

Consider the example of one Stryker Brigade that deployed to Iraq 2006-2007 (the unit designation is not important, however one is reminded that the Stryker Brigades are no ordinary Brigade Combat Team, rather they are considered the tip-of-the-spear when it comes to Army expeditionary units mainly because of the agile and adaptive, smart and technology savvy soldiers and leaders they produce). In an interview with the rear detachment commander, it was noted that the rear detachment was left with approximately 204 personnel. Of the 204 personnel left behind, over the course of a year, 35 individuals (17%) with prior combat deployments and 16 (8%) without previous combat deployments were “chaptered” or removed from the active-duty Army because of misconduct or behavioral disorder; compared with the statistics for the 10 personnel (or 5%) with previous combat deployment experience and one individual (less than 1%) with no previous combat experience that were subjected to courts-martial. Further consider that eleven (or over 5%) of those “chaptered” that had been deployed before committed a violent offense that resulted in their administrative discharge with another six (or 3%) that had no previous combat being administratively discharged for similar offenses. Moreover, another 23 (or 11%) who had previous combat experience and eight (or 4%) that had no prior combat

deployments were administratively discharged for other offenses (non-violent) or disorders - these may have had symptoms of PTSD that caused their behavior or not, we may never know. Regardless, the example of this unit clearly shows another way in which incarceration numbers and the resulting statistics can be deceptively low.

Overall incarceration data for the USDB (archived records for 1916 - 2001 kept in the Combined Arms Research Library, Fort Leavenworth and recent 2002 – 2006 exempt aggregate data released from the facility and gained from the DoD Annual Reports) was available and examined for this research. The data for World War I (WWI) through Vietnam eras appears on surface to support the theory that incarceration rates should increase during times of war if there is a correlation between PTSD and incarceration for violent criminal behavior. For WWI in the years 1916 through 1919, the USDB population rose 98% from 1,083 inmates to 2,142 inmates then the population drops precipitously. A similar pattern emerges for each of the other conflicts (where n= the number of total inmates): World War II (WWII) between a low in 1920 (n=1,299) and 1946 (n=1,843) saw a 42% increase, Korea between 1950 (n=884) and 1952 (n=1,517) experienced a 72% increase while Vietnam from 1965 (n=751) to the height of our involvement in 1968 (n=1,365) had a 82% rise. There also was a second increase (27%) during the Vietnam years (albeit smaller than the previous period) from 1972 (n=940) to 1975 (n=1,190). After the Vietnam era, there is one other period where the inmate population of the USDB shows an increase, namely during the Reagan build-up of the armed forces where from 1980 to 1983 the population rose by thirteen percent. Beginning in 1991, the USDB has seen a steady decrease in the total number of inmates. Several factors contribute to the decrease notwithstanding the obvious decrease in active-duty personnel; for example, the new USDB was opened in 2002 which greatly reduced the operational capacity of the facility.

However, in reality, the mere fact that the population had increased during wartime, as discussed above, when examined against a backdrop of the reasons military personnel were incarcerated over the period, does not by itself support the research hypothesis – though it does

not necessarily refute it either. As David Haasenritter points out, during WWI, the majority of inmates (67%) were incarcerated for a charge of desertion.¹⁶⁴ Again, during WWII and Korea, Mr. Haasenritter reports that “the most frequent offense committed during the wars was desertion.”¹⁶⁵ Finally, Mr. Haasenritter states that for Vietnam, “the most common offense was absent without leave (AWOL).”¹⁶⁶ It is important to note though that for the records available in the archives for 1944 some 122 (or 7%) of inmates confined to the USDB were there because they had committed violent offenses. Similarly, in 1946, 98 (or 5%) of the inmates were held in the USDB for violent offenses. Of course, the experiences of Vietnam veterans have already been discussed whereby they were incarcerated for violent offenses in other facilities. Similar data was unavailable in the archives for WWI and Korea. Though statistically insignificant, the fact that such relatively small percentages of inmates in the WWI, WWII, Korea and Vietnam eras were at the USDB for violent offenses does not refute the current hypothesis.

Perhaps the most compelling support for this research hypothesis comes from the ongoing and recent research of Dr. Galloway and the mental health staff at the USDB. Initial data (see Table 3 below) found that of the inmates currently incarcerated in the USDB (n=440), in response to the survey questionnaire regarding PTSD symptoms, 199 (45%) reported one or more symptoms associated with PTSD, 157 (36%) reported no symptoms and 84 (or 19%) refused to participate in the research. Only seventy-four (37%) inmates who reported symptoms responded that they had not deployed; whereas, 51 (or 32%) of the inmates reporting no symptoms were deployed. A majority of the current inmates at the USDB have deployed. Furthermore, of the inmates who reported symptoms, 95 (48%) answered that they had received fire in combat and 28 (14%) reported having been wounded. Of the 440 inmates surveyed, twenty-three (5% of the

¹⁶⁴ David K. Haasenritter. *A comparative Study of the Demographic Profiles of Prisoners Confined in the Federal and U.S. Army Correctional Systems*. Master of Criminal Justice Thesis. University of South Carolina, Retrieved from URL: <http://stinet.dtic.mil/cgi-in/GetTRDoc?AD=ADA227132&Location=U2&doc=GetTRDoc.pdf> 1990, 27.

¹⁶⁵ Ibid., 31.

total or 12% of those with symptoms) have a diagnosis of PTSD already in their records with all 23 reporting having been deployed. Additionally, of the twenty-three with PTSD, 87% (n=20) reported deployment to a combat zone (57% for one tour, 22% for two tours and 8% for three tours), 74% (n=17) reported having received hostile fire and 43% (n=10) reported being wounded. Also, of those with PTSD, 17 inmates (74%) have a treatment history prior to arrival at the USDB. Regarding their incarcerating offenses, 92% committed violent offenses, one (4%) threatened to kill/conspired to kill another and one (4%) committed a drug offense. Moreover, in reviewing the monthly confinement reports for the four months of the initial phase of the survey (August 2007 – November 2007), > 91% of all the inmates incarcerated in the USDB for the period were being held for violent offenses of both the expressive and instrumental nature.

USDB Inmates with Diagnosed PTSD (Survey Results)

Total Available for Survey	n=440			
Total Participating	n=356	81%		
# Refused to Participate	n=84	19%		
Deployment History			Percentage of Those w/PTSD	Percentage of Total
- Previously Deployed	n=23		100%	6.50%
- Deployed to Combat Zone	n=20		87%	5.60%
- Reported Receiving Hostile Fire	n=17		74%	4.80%
- Wounded in Action	n=10		43%	2.80%
- Deployed Once	n=13		57%	4%
- Deployed Twice	n=5		22%	1.40%
- Deployed Three Times	n=2		8%	0.60%
Confining Offense Category				
- Violent Offense	n=21		92%	6%
- Drug Offense	n=1		4%	0.30%
- Threaten to Kill/Conspire to Kill	n=1		4%	0.30%
Branch of Service/Component				
- USMC	n=3		13%	0.80%
- USAF	n=4		18%	1%
- USA	n=15		65%	18%
- USAR	n=1		4%	0.30%
Race				
- African American	n=5		21%	1.40%
- Caucasian	n=18		78%	5%
Received Treatment Prior to Arrival at USDB	n=17		74%	4.80%

Average Age When 1st Offense Committed: 24 Years Old

Table #3.

¹⁶⁶ Haasenritter, 35.

DISCUSSION

The data presented, particularly the initial results of the current USDB survey, strongly supports the current hypothesis that there is a correlation between PTSD and criminal behavior in soldiers that have been incarcerated after returning from the GWOT. In a broad sense, the results of the Collins and Bailey study demonstrates significant causal links between the onset of PTSD symptoms and the increased risk of and commission of violent criminal acts. The researchers also found significant data supporting that individuals with bonafide PTSD are 4.58 times more likely to be currently imprisoned for an expressive violent act during the time period of their study. Moreover, Collins and Bailey found that over half of their subjects that were diagnosed with PTSD had indicated that the most prevalent cause for their disorder was either witnessing another person being harmed and/or killed with the second most prevalent cause being participation in combat. Our military personnel in large numbers are exposed to both of these stressor events continuously while supporting the GWOT – and not just in Iraq and Afghanistan, but in counter-insurgency operations in the Philippines and other deployments throughout the world. Unlike Vietnam for the most part, military personnel today are being repeatedly deployed into combat zones and frequently they are having the length of the deployments extended. Wilson and Zigelbaum in their 1983 study found that both the length of exposure and the intensity of the exposure to traumatic stressors greatly increased an individual's susceptibility to PTSD and directly linked to the later propensity to commit violent criminal acts.¹⁶⁷ Particularly for our younger military personnel who serve in ever-greater numbers in combat, Wilson and Zigelbaum also found “that the combination of combat stress and psychological isolation during the homecoming period may have impaired negatively on the process of identity formation.”¹⁶⁸

¹⁶⁷ John P. Wilson, Ph.D. and Sheldon D. Zigelbaum, M.D. The Vietnam Veteran on Trial: The Relation of Post-Traumatic Stress Disorder to Criminal Behavior. *In Behavioral Sciences & the Law*, Vol. 1, No. 3. 1983, Obtained from the CARL., 91.

¹⁶⁸ Wilson and Zigelbaum, 71.

One can argue when exactly an individual's identity finally congeals into the mature person they will eventually become; however, one cannot argue with the fact that, for most individuals, the process continues late into their teen years and early twenties. Our young warriors are spending some of their formative years exposed to the very stressors that have been shown to produce violent personalities and criminals.

Furthermore, the BJS reports have shown that significant numbers of veterans from all our wars back to WWII are still incarcerated for mostly violent criminal acts. Ominously, where it previously took years or a decade for veterans of other wars, particularly Vietnam era veterans, to develop full-blown PTSD and commit violence, we are already seeing significant numbers of GWOT veterans appearing in correctional facilities with Iraq and Afghanistan Veterans now representing 3.7% of veterans in State facilities and 4.5% in Federal institutions. The facts that 20% of both Federal and State incarcerated veterans and 21% of those in local jails stated they had been in combat during their military service and over half of the veterans imprisoned in State correctional facilities and just under a quarter of the veterans held in Federal institutions were serving sentences for committing violent acts clearly shows a significant link between combat exposure as a traumatic stressor and violent criminal behavior.

The data regarding DoD incarceration rates directly supports the current hypothesis in that from 2002 (just after the start of the GWOT and operations in Afghanistan) and 2006, significant percentages ($\geq 40\%$) of military inmates were confined for violent criminal offenses (both expressive and instrumental violence). Moreover as noted, between 2003 (the beginning of the Iraq campaign where greater numbers of personnel began serving in combat) and 2005, DoD military incarcerations increased 7.25% and the percentages of inmates confined for violent offenses in relation to the overall DoD inmate population has shown an overall increase of 5.44 percent.

Even more supportive of the current hypothesis is the analysis of initial data from the USDB survey. As can be seen in the research data above, significant numbers of currently

incarcerated military personnel reported having one or more symptoms of PTSD (n=199, or 45% of the total inmate population and 56% of all surveyed) and will undergo face-to-face diagnostic interviews to determine if they in fact have PTSD. A variable we do not know at this time is whether some of the 157 (36%) inmates who reported no symptoms may actually have PTSD but either were afraid to answer positively or who are as yet asymptomatic for PTSD and thus do not realize the impact their combat experience. After all, fifty-one (32%) of those who answered that they were asymptomatic deployed out of that group. We do know that five percent of the total inmate population (n=23, or 12% of those with symptoms) have a diagnosis of PTSD and this in itself represents a significant statistical correlation when most of these offenders (92%) then committed a violent crime. Of these inmates with PTSD, 87% (n=20) have been deployed to combat. Moreover, and quite significantly, all of the seven (30%) who reported being deployed more than once (22% for two tours, 8% for three tours) are confined for violent offenses, albeit one is for culpable negligence in the unlawful killing of another, demonstrating that multiple deployments may have a even more serious role in the causal link between PTSD and violent criminal behavior than has been previously investigated to date. Finally, one must look very seriously at the fact that a majority (>91%) of all inmates currently at the USDB are confined because they committed a violent act. The preliminary results of the USDB multi-tiered survey are consistent with findings of previous research efforts and in particular with knowledge gained during the Vietnam era; as such, as the operations in Afghanistan and Iraq continue, more military personnel may find themselves in trouble with their commands or the civilian legal system.

RECOMMENDATIONS

First and foremost, much more extensive research in the area of PTSD and its relation to individual behavior and an increased predisposition for committing criminal acts must be undertaken. This research merely scratched the surface of a societal problem and as is

discussed in the limitations above and in other areas of the research paper, the full scale and magnitude of the number of veterans affected cannot be ascertained with any certainty using the currently available data. In this regard, the Government Accounting Office (GAO) found in its September 2004 report to Congress on the VA's ability to provide adequate mental health care to veterans that even the VA lacks sufficient data to fully appreciate the prevalence of PTSD in current veterans.¹⁶⁹ Moreover, the GAO found in February 2005 when it followed-up on the findings of the aforementioned report that the VA still lacked adequate data to show evidence that they could meet the needs of an increasing number of veterans with PTSD.¹⁷⁰ Therefore, given this lack of comprehensive empirical data on the true scope of the problem, the first recommendation is that a multi-disciplined, multi-agency research team be created and authorized to gather the necessary data to fully understand and appreciate the magnitude of this complex social problem.

However important the true scope of the problem may be, we as a nation must not idly wait to address the issue. Make no mistake; the DoD and VA have made great strides in care for veterans suffering with PTSD than past efforts and recently each department has begun to implement the recommendations of several congressional reports and presidential commissions. Thus, given the urgency of the problem, it is essential that we expand our efforts in prevention, increase early intervention and treatment programs and adequately resource mitigation efforts when all other options fail to help veterans resulting in the commission of violent criminal acts and incarceration. To this end, prevention efforts must be expanded and standardized including training and the initiation of a concerted effort to change the institutional attitude towards PTSD

¹⁶⁹ Marcia A. Mann, et al., *VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services*. Washington D.C.: United States Government Accountability Office Report. 2004, 3.

¹⁷⁰ Marcia A. Mann, et al., *VA Health Care: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services*. Washington D.C.: United States Government Accountability Office Report. 2005,, 12.

within the force. Entry level training for soldiers and pre-commissioning training up to officer basic branch training must be the toughest, most realistic training available in order to build a solid professional warrior ethos and mental toughness into our new warriors. Mentally tough and confident new soldiers and officers have the solid combat-ready mindset that provides the foundation for coping abilities they will need to process the experiences they will encounter on the modern battlefield.

Similarly, commanders must continue to stress tough, realistic training during the pre-deployment phase that units undergo. The president's commission charged with investigating the status of care afforded our wounded warriors reported in July 2007 that those units "who undergo the most intense, realistic training before deploying to combat tend to experience the fewest associated mental health problems."¹⁷¹ Commanders must take advantage of the Army's Battle Mind training for leaders to master the knowledge "to mitigate risk and build resilience in their soldiers."¹⁷² Soldiers can take advantage of the Battle Mind training to hone skills necessary to survive combat while developing a "psychological hardiness"¹⁷³ to deal appropriately with the "potential emotional responses to combat."¹⁷⁴ Additionally, commanders can use many of the effective strategies and techniques found in Field Manual (FM) 4-02.51 *Combat and Operational Stress Control* to prepare their troops to emotionally survive combat.

Furthermore, despite the officially stated policies regarding non-retribution for those seeking mental health treatments for service related conditions, many servicemen and women still fear negative consequences to seeking assistance for PTSD. Whether their fears of prejudice and discrimination related to their service related condition are justified remains to be seen as veterans

¹⁷¹ Bob Dole and Donna Shalala. *Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors*. Subcommittee Reports & Findings of the Final Report. July 2007, Retrieved from URL: <http://www.pccww.gov/docs/TOC%20Subcommittee%20Reports.pdf> , 38.

¹⁷² Ibid., p.38.

¹⁷³ Thomas Williams, Colonel, *Army Physical Fitness Research Institute Brief, Combat Stress Reactions and Post-Traumatic Stress Disorder*, United States Army War College, Carlisle, PA. Slide 31.

¹⁷⁴ Dole and Shalala, 38.

continue to re-integrate back into society. Regardless, there is a perception of negative consequences that continues to influence an individual's decision to not seek help in dealing with the psychological consequences of their combat experiences. Leaders at all levels must show through their actions, not merely words, that soldiers who seek treatment will not suffer repercussions in their careers for seeking that help. Senior leaders must be willing to show junior leaders and soldiers that in seeking help, they aren't exposing a weakness of character. It is precisely this courageous leadership that led Command Sergeant Major Samuel M. Rhodes, Sr. to relate his personal battle with PTSD in the July-August 2007 issue of *Infantry*.¹⁷⁵ Similarly, leaders at all levels must avoid making disparaging comments about the mental health issues and programs established to help ameliorate the problem of PTSD. Many leaders fail to realize the magnitude of the problem or view the mandatory briefings as actually causing or exacerbating the prevalence of the PTSD in the force.¹⁷⁶

Moreover, the Dole/Shalala Report has identified that there exists a cultural "stigma" associated with seeking treatment for psychological problems.¹⁷⁷ Cultural bias against those with mental health problems is not a new phenomenon and there are no easy answers as to ways to alter this issue. As discussed earlier in this paper, bias against those with PTSD has been a fact of life throughout history and modern media can compound the problem by continuing to portray combat veterans in movies and television shows as crazy malcontents who cannot be trusted to

¹⁷⁵ Command Sergeant Major Samuel M. Rhondes, Sr. served as the brigade command Sergeant Major for the 192nd Infantry Brigade at Fort Benning, Georgia when he wrote an article in the Professional Forum of *Infantry* entitled: *Post Traumatic Stress Disorder Impacts All Levels of Leadership*. July-August 2007.

¹⁷⁶ The Advanced Military Studies Program had just received the Department of the Army PTSD chain-teaching and several seminars were conducting After Action Reviews and more than a few students remarked in the presence of this researcher that they hoped the mandatory training would not cause a problem where there was no problem. This researcher has heard this same comment and attitude repeated several times by senior leaders and in different venues.

¹⁷⁷ Bob Dole and Donna Shalala. *Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors*. Final Report. July 2007, Retrieved from URL: http://www.pccww.gov/docs/Kit/Main_Book_CC%5BJULY26%5D.pdf, 18.

re-enter society.¹⁷⁸ Therefore, Congress must consider strengthening anti-discrimination laws to protect veterans who have sought counseling for service related mental health problems. At the same time, Hollywood producers should be strongly encouraged to accurately portray veterans and their issues in all media and avoid the negative sensationalized violent stereotypes which can be linked back to only a very small minority of veterans.

As with preventative measures, early intervention and treatment shortly after an individual begins to exhibit symptoms or is showing indications of susceptibility to PTSD is equally critical in preventing the onset of full-blown PTSD or affecting a rapid recovery. To ensure soldiers have the best chances to avoid developing PTSD, or quickly recover and return to duty, the DoD has been deploying Stress Control Teams embedded with units in Iraq and Afghanistan.¹⁷⁹ Similarly, DoD has required units and individuals to undergo Post-deployment Health Assessment (PDHA) and Post-deployment Health Reassessment (PDHRA) questionnaires to identify at-risk personnel and refer them for an interview with a mental health professional and treatment if necessary.¹⁸⁰ The individual's post-deployment results are compared with the results of pre-deployment questionnaires before a referral is made in each case. The fact remains that except for extreme cases, treatment is voluntary and even discussing the results of the questionnaires with a mental health professional is voluntary – many soldiers opt not to seek the further referral. In each of the DoD efforts, as the American Psychological Association's Presidential Task Force reported in February 2007, the problem remains a critical shortage of specially trained psychologists and mental health professionals to ensure all requirements are met (both to deploy and remain stateside) and care is available in all locations for all affected soldiers.

¹⁷⁸ Cliva Louise Mee. *Vietnam Veterans in the Criminal Justice System: an Attitudinal Study to Access Possible Bias*. Submitted in partial satisfaction of the requirements for the degree of Master of Social Work at California State University, Sacramento. May 12, 1980, 15-18.

¹⁷⁹ Shannon J. Johnson, et al., *The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report*. American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. Retrieved from URL: <http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf>, February 2007, 7.

¹⁸⁰ Johnson, et al., 32.

In addition to personnel shortages, a lack of standardization in installation programs has created a situation where some locations have very good programs (as in the case with the Soldier's Wellness Assessment Pilot Program (SWAPP) at Fort Lewis, Washington) and other locations have less comprehensive programs or soldiers have to travel great distances to receive treatment at a DoD or VA facility (as is the case with some in the Reserves and National Guard). Thus, funding must be immediately made available to recruit, train and employ adequate numbers of psychologists, psychiatrists and mental health professionals to fill all requirements in order to have appropriate levels of care available to all soldiers in need regardless of location. Moreover, the DoD must determine the best-practice installation program and standardize its tenets across all DoD locations.

Although the best case scenario is to prevent or treat PTSD before the disorder can have a lasting detrimental effect on an individual, some personnel may nevertheless be immune to all attempts to stave-off the development of debilitating PTSD. These individuals are the ones most susceptible to committing a violent criminal offense and subsequently becoming incarcerated. Results of this research have shown, the incarceration of these veterans will put an extreme burden on both the civilian and military corrections systems. Current personnel authorizations and resourcing for the mental health sections in the USDB and Army Regional Corrections Facilities (RCF) are based on the mental health needs of a peacetime inmate population and geared towards the psychological concerns associated with incarceration and other behavioral disorders (i.e. depression, substance abuse, sexual abuse, etc). The mental health sections are not staffed to deal with a large influx of prisoners with PTSD. As early as March 2001 (before the current conflict), a USMEDCOM (United States Medical Command) assessment team of mental health professionals visited all the Army corrections facilities and among the many findings were

the following:

“The overall delivery of mental health services within the army corrections system sorely needs upgrading.”¹⁸¹

Moreover, among the team’s recommendations were to have the “RCF’s receive adequate funding to comply with U.S. Code and national standards regarding mental health evaluations and treatment of inmates” and that mental healthcare staffing should be increased at the RCF’s while “USDB mental health staffing remain at least at current levels.”¹⁸²

Two important observations must be noted in the discussion of the team’s findings. First, the team did not have the benefit of seeing the current situation as presented in the findings of this current research and the effects that an influx of inmates with PTSD is having on military and civilian corrections. Second, it is important to note that DoD corrections is a program that is intensely regulated and compliance assessments and inspections are frequent and conducted under the scrutiny of numerous agencies, both civilian and military. This researcher is not suggesting that DoD corrections programs are broken; rather, due to the increase in PTSD in inmates and a lack of trained professionals across the force, the system is stressed and it is difficult at best to provide the inmates with the specialized care needed to treat PTSD. Without specialized care for PTSD while incarcerated in a military corrections facility, the likelihood of recovery from the disorder is limited and upon release and discharge from the service, many veterans will remain susceptible to violent criminal behavior and incarceration in civilian facilities. Thus it is imperative that resources and personnel be made available to address the treatment of veteran inmates whether they are confined in military or civilian correctional facilities.

¹⁸¹ C.J. Diebold, M.D. (Lieutenant Colonel), et al., United States Army Medical Command Information Paper, Subject: *Army Correctional Facilities and the Status of Mental Health Treatment*, Dated 9 March 2001, Copy furnished by United States Disciplinary Barracks, 1.

¹⁸² Diebold, 2.

CONCLUSION

The research examined herein as part of this study shows a significant correlation between PTSD and violent criminal behavior in veterans who have been incarcerated. Our nation has a long history, albeit sometimes with mixed results, of providing care and compensation to veterans in return for their service and sacrifice to the nation. These efforts reach back to the pilgrims who enacted “the first pension law in America” to care for veterans.¹⁸³ From this early effort at veterans benefits throughout our nation’s history of conflict, compensation for veterans has undergone several permutations from the early promise of complete care throughout the remainder of the veteran’s life to the complex and bureaucratic system of disability compensation we have in place today. Besides the codification of veterans compensation in law and policy, America has a moral obligation to understand the issues facing veterans and take action to care for those men and women and their families. Many nations, like Canada and the United Kingdom, have well-structured and professionally administered veterans compensation programs based on “an implicit social covenant that must be [honoured].”¹⁸⁴ Americans must rise to the occasion in properly caring for our nation’s veterans particularly in our all-volunteer force (AVF) as a very small minority of citizens provide protection and sacrifice much for the majority.

The subject of PTSD and violent criminal behavior in veterans remains a contemporary issue and one that must be addressed. A recent article in the *New York Times* has truly brought the problem to the forefront of American consciousness as they reported that some “349 homicides involving all active-duty military personnel and new veterans in the six years since

¹⁸³ Nancy C. Andreasen, et al. *PTSD Compensation and Military Service*. Washington, D.C.: The National Academies Press. 2007. Retrieved from URL: http://books.nap.edu/openbook.php?record_id=11870&pages=81, 1.

¹⁸⁴ Andreasen, 2.

military action began in Afghanistan, and later Iraq” have been committed in the United States.¹⁸⁵ The article goes on to claim that this rate of homicides “represents an 89-percent increase over the previous six-year period.”¹⁸⁶ America is at a crossroads on this issue and with the recent publicity and public concern for veterans’ issues at a peak, as a nation we must come to fully appreciate the problem and take actions to properly care for veterans before they land in trouble with the law.

¹⁸⁵ Deborah Sontag and Lizette Alvarez. War Torn: Across America, Deadly Echoes of Foreign Battles. In *The New York Times*. January 13, 2008. Retrieved from URL: <http://www.nytimes.com/2008/01/13/us/13vets.html>, 1.

BIBLIOGRAPHY

- Andreasen, Nancy C., et al. *PTSD Compensation and Military Service*. Washington, D.C.: The National Academies Press. 2007. Retrieved from URL:
http://books.nap.edu/openbook.php?record_id=11870&pages=81
- Baker, Claudia, MSW, MPH, and Cessie Alfonso, LCSW. *PTSD and Criminal Behavior*, A National Center for PTSD Fact Sheet. US Department of Veterans Affairs. Retrieved 11 August 2007 from URL:
http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_legal.html?opm=1&rr=rr91&srt=d&echorr=true
- Bartol, Curt R. and Anne M. Bartol. *Criminal Behavior: A Psychosocial Approach*, 7th Edition. Upper Saddle River, NJ: Prentice Hall. 2005.
- Binneveld, Hans. *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry*. Translated by John O’Kane. Amsterdam: Amsterdam University Press. 1997.
- Brett, Elizabeth A. The Classification of Posttraumatic Stress Disorder. In Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp. 129-154). New York/London: The Guilford Press. 2007.
- Cantrell, Bridget C., Ph.D, and Chuck Dean. *Down Range: To Iraq and Back*. Word Smith Publishing. Seattle, Washington, 2005.
- Collins, James J., and Susan L. Bailey. Traumatic Stress Disorder and Violent Behavior. In *Journal of Traumatic Stress*, Vol. 3, No. 2, 1990. Obtained from the CARL Library.
- Diebold, C.J., M.D. (Lieutenant Colonel), et al., United States Army Medical Command Information Paper, Subject: *Army Correctional Facilities and the Status of Mental Health Treatment*, Dated 9 March 2001.
- Dole, Bob, and Donna Shalala. *Serve, Support, Simplify: Report of the President’s Commission On Care for America’s Returning Wounded Warriors*. July 2007, Retrieved from URL:
http://www.pccww.gov/docs/Kit/Main_Book_CC%5BJULY26%5D.pdf 18.
- Dole, Bob and Donna Shalala. *Serve, Support, Simplify: Report of the President’s Commission On Care for America’s Returning Wounded Warriors*. Subcommittee Reports & Findings of the Final Report. July 2007, Retrieved from URL:
<http://www.pccww.gov/docs/TOC%20Subcommittee%20Reports.pdf>
- Doyle, Edward, and Stephen Weiss, et al. *The Vietnam Experience: A Collision of Cultures*. Boston: Boston Publishing Co. 1984.
- Effros, William G. *Quotations Vietnam: 1945-1970*, Random House, New York, 1970.
- “Former Prisoners of War Get Help in a Nashville Program.” *New York Times*. December 8,

¹⁸⁶ Sontag and Alvarez, 1.

1987. Obtained from URL:
<http://query.nytimes.com/gst/fullpage.html?res=9B0DEFD61E39F93BA35751C1A961948260>
- Frances, Allen M.D. (Chair), et al. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. American Psychiatric Association, Arlington, VA. 2000.
- Freud, Sigmund. Introduction to Psycho-Analysis and the War Neuroses. In Mardi J. Horowitz (Editor), *Essential Papers on posttraumatic Stress Disorder*. New York and London: New York University Press. 1999.
- Haasenritter, David K. *The Military Correctional System: An Overview*. Retrieved from URL:
<http://www.aca.org/publications/ctarchivespdf/dec03/hassenritter.pdf>
- Haasenritter, David K. *A comparative Study of the Demographic Profiles of Prisoners Confined in the Federal and U.S. Army Correctional Systems*. Master of Criminal Justice Thesis. University of South Carolina, Retrieved from URL:
<http://stinet.dtic.mil/cgi-in/GetTRDoc?AD=ADA227132&Location=U2&doc=GetTRDoc.pdf> 1990, 27.
- Hendrin, Herbert and Ann Pollinger Haas. *Wounds of War: The Psychological Aftermath of Combat in Vietnam*. New York: Basic Books, Inc. 1984.
- Hicks, Robert M. and Randy Petersen. *Returning Home: Practical Advice for War Veterans, Their Families and Friends*. Tarrytown, New York: Fleming H. Revell Co. 1991.
- Hoge, Charles W., MD., et al. Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. In *The New England Journal of Medicine*, Vol. 351:13:22, 2004. Retrieved 11 August 2007 from URL: <http://content.nejm.org/cgi/content/full/351/1/13>
- Horowitz, Mardi J., et al. *Essential Papers on Posttraumatic Stress Disorder*. Edited by Mardi J. Horowitz. New York and London: New York University Press. 1999, 19.
- Isthoff, Michael, and Jamie Reno. Veterans: "How Do You Fund a War, But Not the Casualties?" *Newsweek*. 29 October 2007.
- Johnson, Shannon J., et al., *The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report*. American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. Retrieved from URL: <http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf>, February 2007.
- Keegan, John. *The Face of Battle*. New York, New York: Penguin Books. 1976.
- Kulka, Richard A. Ph.D, et al. *Trauma and the Vietnam Generation: Report of Findings from the National Vietnam Veterans Readjustment Study*. New York: Brunner/Mazel. 1990.
- Litz, Brett T. *A Brief Primer on the Mental Health Impact of the Wars in Afghanistan and Iraq*. A National Center for PTSD Fact Sheet. US Department of Veterans Affairs. Retrieved 11 August 2007 from URL:
http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_iraq_afghanistan_lay_audien.html

- Maclear, Michael. *The Ten Thousand Day War: Vietnam, 1945-1975*. New York: St Martin's Press. 1981.
- Mann, Marcia A., et al., *VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services*. Washington D.C.: United States Government Accountability Office Report. 2004.
- Mann, Marcia A., et al., *VA Health Care: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services*. Washington D.C.: United States Government Accountability Office Report. 2005.
- McFarlane, Alexander and Giovanni De Girolamo. The Nature of Traumatic Stressors and Epidemiology of Posttraumatic Reactions. In Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp. 129-154). New York/London: The Guilford Press. 2007.
- McNally, Richard J. *Remembering Trauma*. Cambridge, Massachusetts and London, England: The Belknap Press of Harvard University Press. 1994.
- Mee, Cliva Louise. *Vietnam Veterans in the Criminal Justice System: an Attitudinal Study to Access Possible Bias*. Submitted in partial satisfaction of the requirements for the degree of Master of Social Work at California State University, Sacramento. May 12, 1980.
- Mumola, Christopher J., *Veterans in Prisons or Jails*. Bureau of Justice Statistics Special Report (NCJ178888), 2000. U.S. Department of Justice, Office of Justice Programs. Washington D.C. Retrieved from URL: <http://www.ojp.usdoj.gov/bjs/> .
- Noonan, Margaret E. and and Christopher J. Mumola, *Veterans in State and Federal Prison 2004*. A Bureau of Justice Statistics Special Report (NCJ217199), May 2007. U.S. Department of Justice, Office of Justice Programs. Washington D.C. Retrieved 12 October 2007 from URL: <http://www.ojp.usdoj.gov/bjs/pub/press/vsfp04pr.htm>
- Rafferty, Heidi. "Ghosts and Demons': Vietnam Vets Coping with PTSD., *VFW Magazine*. November 2007.
- Roberts, Cheryl A. *Coping with Post-Traumatic Stress Disorder: A Guide for Families*. Jefferson, North Carolina: McFarland & Company, Inc. 2003.
- Rhondes, Sr., Samuel M., Command Sergeant Major. Post Traumatic Stress Disorder Impacts All Levels of Leadership. In *Infantry*. July-August 2007.
- Shay, Jonathan, MD, Ph.D. *Achilles in Vietnam: Combat Trauma and the Undoing of Character* New York: Scribner. 1994.
- Smith, John Russell. *A Review of One Hundred and Twenty Years of the Psychological Literature on Reactions to Combat from the Civil War through the Vietnam War 1860 1980*. Doctoral Thesis submitted to the Department of Psychology, Duke University. Durham, North Carolina. 1981.
- Spitzer, Robert L., MD, (Chair), et al. *Diagnostic and Statistical Manual of Mental Disorders*

- 3rd Edition-Revised. American Psychiatric Association, Washington, D.C., 1987.
- Tan, Michelle. (2006). By the numbers: Who's Fighting. *The Army Times*. A Gannet Newspaper. Retrieved on 10 December 2006 from URL:
<http://www.armytimes.com/story.php?f=1-292925-2395712.php>
- U.S. Department of the Army, FM 4-02.51(FM8-51), *Combat and Operational Stress Control* Washington D.C.: Government Printing Office, July 2006.
- VA/DoD *Clinical Practice Guideline For The Management of Post Traumatic Stress: InterventionsModule Summary*. December 2003. Retrieved from URL:
http://www.oqp.med.va.gov/cpg/PTSD/G/Interv_Sum508.pdf
- Van der Kolk, Bessel A. The Complexity of Adaptation to Trauma Self-Regulation, Stimulus Discrimination, and Characterological Deveolpment. In Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp. 182-213). New York/ London: The Guilford Press. 2007.
- Weaver, Suellen F. and Nora Kinzer Stewart. *Factors Influencing Combat Stress Reactions and Post-Traumatic Stress Disorder: A Literature Review*. U.S. Army Research Institute for the Behavioral and Social Sciences. Alexandria, Virginia: Department of the Army. 1988.
- Williams, Thomas, Colonel, *Army Physical Fitness Research Institute Brief, Combat Stress Reactions and Post-Traumatic Stress Disorder*, United States Army War College, Carlisle, PA.
- Wilson, John P., Ph.D. and Sheldon D. Zigelbaum, M.D. The Vietnam Veteran on Trial: The Relation of Post-Traumatic Stress Disorder to Criminal Behavior. *In Behavioral Sciences & the Law*, Vol. 1, No. 3. 1983. Obtained from the CARL Library.