

PTSD in Military Service Members

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PTSD in Military Service Members

To Care for Him Who Shall Have Borne the Battle

Posttraumatic Stress Disorder (“PTSD”) is the most prevalent mental health disorder among our military service members.¹ The diagnosis of stress from combat has evolved historically as a controversial topic.² PTSD results from exposure “to actual or threatened death, serious injury, or sexual violence.”³ To qualify for a diagnosis of PTSD, one’s symptoms must last for more than one month.⁴ These symptoms include: intrusive thoughts or nightmares; avoidance of triggers of the trauma; negative changes in cognitions and mood; and heightened arousal and reactivity.⁵ These symptoms must also cause “significant distress or impairment in social, occupational, or other important areas of functioning.”⁶ In establishing a diagnosis of PTSD, a mental health professional must consider: (1) the nature of the traumatic event, (2) evaluate the presence, intensity and frequency of symptoms, and (3) note a link between the symptoms and the traumatic event.⁷

The diagnosis of PTSD among military service members and veterans is riddled with competing political agendas focused upon the cost of war. Political actors that support war seek to minimize the cost of war, while those political actors that do not support war seek to maximize the

¹ Benjamin R. Karney et al., *Invisible Wounds: Predicting the Immediate and Long-Term Consequences of Mental Health Problems in Veterans of Operation Enduring Freedom and Operation Iraqi Freedom*, 21 (2008) (unpublished manuscript) (on file with Center for Military Health Policy Research), https://www.rand.org/content/dam/rand/pubs/working_papers/2008/RAND_WR546.pdf.

² See e.g. Richard McNally, *Troubles in Traumatology*, 50 CAN. J. PSYCHIATRY 815 (2005), <http://journals.sagepub.com/doi/abs/10.1177/070674370505001301>.

³ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC & STATISTICAL MANUAL: MENTAL DISORDERS § 309.81(A) (5th ed. 2013) [hereinafter “DSM-5”].

⁴ *Id.* at § 309.81(F).

⁵ *Id.* at § 309.81(B).

⁶ *Id.* at § 309.81(G).

⁷ Mary Tramontin, *Exit Wounds: Current Issues Pertaining to Combat-Related PTSD of Relevance to the Legal System*, 29 DEV. MENTAL HEALTH L. 23, 26 (2010).

cost of war.⁸ This conflicting political agendas affects the funding, support, and care provided to veterans for the trauma they endured during the war. The cost of war is often calculated as the immediate cost of the war itself. Congress has approved \$1.6 trillion for the immediate costs of war, which includes military operations, base support, weapons maintenance, training of Afghan and Iraq security forces, reconstruction, foreign aid, embassy costs, and some veterans' health care for the war operations.⁹ However, unaccounted costs have been estimated at approximately \$6.2 billion for the "War on Terror" since September 11, 2001.¹⁰ These unaccounted costs include the societal costs of PTSD; which includes loss of productivity, unemployment, costs of treatment, and suicide. Thus, in order to minimize the cost of war, veterans are improperly denied mental health care and benefits.

Service members undergo unique training to prepare for combat. During this rigorous training, they are taught to put the mission as well as the well-being of their fellow service members above their own. Throughout the stages of deployment, service members face a unique set of experiences that are vastly different from the experiences of civilians. However, service members are subjected to the same general PTSD diagnostic criteria as civilians.¹¹ This overly general diagnostic criteria directly influences whether veterans are awarded benefits. It also shapes societal norms and attitudes toward veterans who have experienced the unique stress of training and deployment. Finally, it impacts legislative policy and legal decisions.

Mental health issues can emerge from a far more diverse set of unique military experiences than traditional fear-based stressors. Service members' training, experiences during duty, process

⁸ M. Gregg Bloche, *The Hippocratic Myth: Why Doctors Are Under Pressure to Ration Care, Practice Politics, and Compromise their Promise to Heal* 67–70 (2011).

⁹ Amy Belasco, *The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11* 1 (Dec. 2014) (CONG. RES. SERV. Report for Congress), <https://www.crsreports.com/result#r=RL33110>.

¹⁰ H.R. REP. NO. 110-789 at 14 (2008).

¹¹ *DSM-5* at § 309.81.

of deployment, presence in a combat zone, and post-deployment adjustment may be inherently traumatic. These unique stressors include direct life threatening experiences as well as indirect stressors that are uniquely present in the experiences of service members. Given the nature of military training, in which soldiers are taught to fight for their fellow service members, the loss of one of their brothers is uniquely traumatic. Additionally, service members are taught to make split second decisions in order to protect their brothers, which may lead a service member to kill an innocent civilian or child in a warzone. Finally, adjustment into civilian life after active duty poses its own unique set of stressors as soldiers are no longer surrounded by their brothers that shared their unique experiences and training.

This Article will argue that under the current inadequate PTSD diagnostic criteria, service members are discriminatorily denied necessary benefits and care.¹² Part I of this Article will discuss the unique experiences of military training, which differentiate service members from civilians. Part II will examine the unique experiences of service members throughout the deployment cycle. Part III will analyze the current law regarding veterans with PTSD that apply for benefits in the form of compensation. Part IV will address the stigma surrounding a PTSD diagnosis in service members. Finally, Part V will propose separate diagnostic criteria for military stress, in light of the unique training and experiences of soldiers.

¹² See e.g. *Moran v. Peake*, 525 F.3d 1157, 1158 (Fed. Cir. 2008) (The Federal Circuit held “the term ‘engaged in combat with the enemy’ in [38 U.S.C. § 1154(b)] requires that the veteran have personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality, as determined on a case-by-case basis. A showing of no more than service in a general ‘combat area’ or ‘combat zone’ is not sufficient to trigger the evidentiary benefit of § 1154(b).”).

I. Unique Experiences of Military Training

A. Enlistment: Focus upon the Individual

An individual is often recruited by the military with the promise that he or she will become a better person by pursuing a respectable and courageous mission for his or her country.¹³ Military recruiters often target young, working-class individuals at community colleges.¹⁴ Younger individuals are targeted because they adapt better to military training.¹⁵ Individuals with working class backgrounds are generally more susceptible to recruitment tactics given their potentially limited career options.¹⁶ In order to persuade these individuals to enlist, military recruiters convince these individuals that they will improve their career path, socio-economic status, and their standing within society.¹⁷

B. Basic Training: Focus Upon the Group

While the choice to enlist is often influenced by the pursuit of one's own individual goals, once enlisted, basic training shifts the focus of new recruits from their own self-identities to the identity of the unit.¹⁸ Basic training is an intense indoctrination meant to change the values and loyalties of recruits.¹⁹ This indoctrination occurs across all branches of the military. While nothing can fully prepare service members for the reality of combat, basic training seeks to instill the skills, reactions, and loyalty that provides them with the confidence necessary to enter the battlefield.²⁰

¹³ Jorge Mariscal, *The Making of an American Soldier: Why Young People Join the Military*, ALTERNET.ORG (June 25, 2007) <http://tinyurl.com/hkl9pda>.

¹⁴ Mariscal *supra* note 13.

¹⁵ GWYNNE DYER, WAR 38 (2005), <http://tinyurl.com/hyr7sy2>; Mariscal, *supra* note 13.

¹⁶ Ann Scott Tyson, Military Recruiters Target Isolated, Depressed Areas, THE SEATTLE TIMES, (Nov. 9, 2005) <http://www.seattletimes.com/nation-world/military-recruiters-target-isolated-depressed-areas/>.

¹⁷ Mariscal *supra* note 13.

¹⁸ Robert Novaco et al., *Military Recruit Training: An Arena for Stress Coping Skills*, 3 (1989), <http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA097816>; Harold Braswell & Howard Kushnera, *Suicide, Social Integration, and Masculinity in the U.S. Military*, 74 SOC. SCI. MED. 4 (2010).

¹⁹ Dyer, *supra* note 15, at 44.

²⁰ *Id.*

When entering combat, service members risk their lives because they are confident that other members of their unit will take risks equally as great to save them from danger.²¹ This confidence is achieved by teaching the recruits that they are the strongest, most disciplined, most dedicated soldiers in the world, who are part of the most rigorously trained and best-equipped military in the world.²²

In basic training, new recruits are stripped of their individual identity as well as their prior self-image.²³ On the first day of boot camp, the recruits surrender their own clothes, shave off their hair, and are purged of all physical evidence of their prior civilian identity.²⁴ The recruits are no longer individuals but rather become a collective group that is expected to dress in the same required uniform and adhere to the same required code of conduct. This is the first step of transformation from their prior civilian life to their military life.

At boot camp, new recruits are separated from their existing emotional ties as well as their former life outside the military. This separation forces them to focus entirely upon the mission of training as well as the unit.²⁵ Drill sergeants depersonalize the individual identities of a diverse group of recruits through harsh disciplinary routines.²⁶ These recruits endure harsh exercises and stern discipline because they are romanticized by the idea that through this process they will become individuals with high social standing.²⁷ This training is targeted at destroying the individual's prior beliefs and confidence through constant abuse that instills hopelessness in the

²¹ *Id.*

²² Brian Mockenhaupt, *The Army We Have*, THE ATLANTIC (June 2007), <https://www.theatlantic.com/magazine/archive/2007/06/the-army-we-have/305902/>.

²³ Madeline Morris, *By Force of Arms: Rape, War, and Military Culture*, 45 DUKE L. J. 651, 728 (1996).

²⁴ *Id.*

²⁵ *Id.*

²⁶ Braswell, *supra* note 18.

²⁷ Dyer, *supra* note 15.

recruit.²⁸ The difficulty of training rituals increases with the deliberate purpose of breaking down the recruits so that they are forced to accept the values instilled into them by the military.²⁹

During drills, they are required to chant in unison and march in formation to re-enforce the idea of a uniform, collective group.³⁰ The recruits are taught to sacrifice their own life to preserve the unit in order to be efficient in combat.³¹ Through this training, individuals learn to view themselves less as individuals and more as members of a group.³² By adhering to the collective values and norms of the group, the recruit earns the respect of the group.³³ This collective respect is valued above one's own self-respect as the soldier's identity is defined by the soldier's membership and acceptance within their unit.³⁴ Thus, the process of basic training is built around fostering strong bonds between recruits.

During basic training, recruits spend every waking moment together with their brothers. Together, they share the mistake of one individual as a group through collective punishment.³⁵ A former Army Infantryman recollected collective punishment during his first few days of basic training in the following statement:

[T]wo recruits left the barracks and walked toward town [. . .] A drill sergeant driving home picked them up a short distance from the barracks. We were awakened, told what had happened, and told we would be dealt with later. We fell back asleep knowing the morning would bring pain. "So you want to play games?" one of our drill sergeants said. "OK, we will play games." He ordered us to squat and hold out our arms. The two recruits stood in front of the formation, watching us and looking sheepish. "Don't be mad at me; be mad at your friends standing up here [. . .] I am not doing this to you—they are doing this to you. Are you tired? Do your legs hurt?

²⁸ *Id.*

²⁹ *Id.*

³⁰ Morris, *supra* note 23.

³¹ Braswell, *supra* note 18.

³² Morris, *supra* note 23, at 728.

³³ Matthew H. Bowker & David P. Levine, *Beyond the Battlefield: "Moral Injury" and Moral Defence in the Psychic Life of the Soldier, the Military, and the Nation*, 16 ORGANISATIONAL SOC. DYNAMICS 85 (2016).

³⁴ *Id.*

³⁵ Dyer, *supra* note 15.

You can look toward the sky and say, ‘God, why is this happening to me?’”³⁶

This shared experience of collective punishment reinforces the recruits’ self-identity as a member of a collective, uniform group. Often fellow service members refer to each other as brothers because the strength of their bonds.³⁷ However, the strength of their bonds is rarely replicated in the civilian world as most civilians are not taught to die for their co-workers. Thus, the bond amongst service members is unique.

II. Unique Experiences of Service Members during the Deployment Cycle

A. Unique Pre-Deployment Stressors

Mental health issues emerge from a far more diverse set of warzone experiences than traditional fear-based stressors, which are present in civilian life.³⁸ The deployment cycle consists of pre-deployment, deployment, and post-deployment. Prior to deployment, service members face several unique stressors. The pre-deployment stage begins with notification of deployment. This notice is often given within a short time frame.³⁹ Additionally, notice usually only includes limited details as to the soldier’s destination of deployment as well as length of deployment.⁴⁰ To further contribute to the uncertainty, deployment orders are often changed for logistical and strategic reasons.⁴¹

Upon notification, a soldier begins to practically and emotionally prepare for deployment. This “ramping up” period lasts between two and four weeks.⁴² In this ramping up period, the soldier

³⁶ Mockenhaupt, *supra* note 22.

³⁷ Morris, *supra* note 23, at 692.

³⁸ Joseph Currier et al., *Moral Injury, Meaning Making, and Mental Health in Returning Veterans*, 71 J. CLINICAL PSYCHOL. 229, 230 (2015).

³⁹ Tramontin, *supra* note 7, at 30.

⁴⁰ *Id.*

⁴¹ Stephen Cozza et al., *Topics Specific to the Psychiatric Treatment of Military Personnel*, 2 IRAQ WAR CLINICIAN GUIDE 4 (2004) <http://tinyurl.com/zkqjqr>.

⁴² Tramontin, *supra* note 7, at 30.

must begin to psychologically focus upon the mission ahead. Although service members are confident of the skills they obtained through basic training, they still worry about the safety of themselves and their unit as they face the pending reality of entering a warzone. Additionally, as deployment requires the soldier to separate from their loved ones for at least seven to fifteen months, they worry about the well-being of their families during deployment.⁴³ In order to prepare for adverse outcomes of deployment, soldiers review wills, financial plans, powers of attorney, contingency childcare arrangements, and emergency contact procedures.⁴⁴

The combination of these stressors is unique to service members in the pre-deployment stage. Individuals in civilian life may worry about uncertainty, their families, and safety. However, since most soldiers are under age 35 and have young children, they must engage in this realistic as well as extensive family and financial planning at a much earlier stage in life than most civilians.⁴⁵ This practical planning forces soldiers to face the risk that they may die in the line of duty. However, they also must remain confident in the mission and trust that they will be protected by their brothers and return home safely. Thus, this combination of stressors in the pre-deployment phase is unique to service members as it cannot be easily equated to experiences of civilians.

B. Unique Stressors of Deployment

During basic training, recruits are desensitized to violence. However, this desensitization cannot fully prepare a service member for the horrifying experience of war. Combat itself is one of the most potent stressors that can be experienced by an individual. In addition to the stress of

⁴³ *Id.*

⁴⁴ *Id.* at 31.

⁴⁵ Office of the Deputy Assistant Secretary of Defense, *Demographic Reports: 2014 Demographics: Profile of the Military Community*, MILITARYONESOURCE.MIL, 35–38, 42–51, 137–145, <http://download.militaryonesource.mil/12038/MOS/Reports/2014-Demographics-Report.pdf> (last visited Mar. 28, 2017).

being separated from their families, service members encounter threats to their own lives as well as to the lives of their brothers. In the Soldier's Creed, service members pledge that they will not leave another service member behind.⁴⁶ On the battlefield, the trauma of war is a shared experience among soldiers. It is likely that unit members will be injured or killed. Nevertheless, the overall attitude of the unit is to dismiss emotion as it is not helpful to survival under the circumstances as survival can only be achieved by continuing to fight and kill.⁴⁷

Given the strength of the bond between soldiers that is instilled in basic training, if a soldier is killed or injured in combat, fellow soldiers may suffer from survivor guilt. Survivor guilt occurs when one identifies with a sense of responsibility for the killing or injuring of another.⁴⁸ Surviving soldiers may blame themselves for not taking adequate action to protect their brother.⁴⁹ Additionally, surviving soldiers may feel unworthy for being spared from the harm that their brother faced.⁵⁰ The strong bond between brothers combined with the shared experience of battle may lead a service member to believe that he could or should have been harmed rather than his brother. These feelings may lead a soldier to lose their sense of control as they question the random nature of the harm that occurred to their brother.⁵¹

When an individual is killed in combat, it is frequently under sudden and horrific circumstances. In war, service members are not provided with adequate time to grieve as they must maintain emotional control in order to focus upon the mission and survival. In some instances of

⁴⁶ *Soldier's Creed*, ARMY.MIL, <https://www.army.mil/values/soldiers.html> (last visited Mar. 28, 2017).

⁴⁷ Tine Molendijk et al., *Conflicting Notions on Violence and PTSD in the Military: Institutional and Personal Narratives of Combat-Related Illness*, 40 *CULTURE MED. PSYCHIATRY* 338, 349–50 (2016).

⁴⁸ Robert Jay Lifton, *The Concept of a Survivor*, in *SURVIVORS, VICTIMS, AND PERPETRATORS: ESSAYS ON THE NAZI HOLOCAUST* 113, 118 (Joel E. Dimsdale, M.D. ed., 1980).

⁴⁹ JAMES HALPERN & MARY TRAMONTIN, *DISASTER MENTAL HEALTH: THEORY & PRACTICE* 96 (2007).

⁵⁰ *Id.*

⁵¹ Heidi A. Wayment, *It Could Have Been Me: Vicarious Victims and Disaster-Focused Distress*, 30 *PERSONALITY & SOC. PSYCHOL. BULL.* 515, 525 (2004).

death on the battlefield, no bodily remains exist. If bodily remains do exist, the body may be in terrible condition and not completely whole. Under these circumstances, fellow service members are tasked with retrieving and handling the remains of their brother. Handling these remains and facing the negative effects of the violent death of a brother is an extremely traumatic task.⁵² Additionally, obstacles such as enemy fire may complicate or prevent the process of retrieving the body. This unique scenario faced by service members significantly complicates a service member's grief.

i. Unique Moral and Ethical Stressors of Combat

Combat also poses moral and ethical challenges to soldiers. This conflict of ethical and moral values may cause the trauma of a moral injury. Moral injury occurs when one realizes they have committed an act with real and terrible consequences.⁵³ The soldiers' sense of loyalty, which is instilled through basic training, overrides their prior civilian values. Most individuals would not voluntarily kill another human being if such action can be avoided. However, participation in combat forces a service member to kill other human beings, which is an action that is in opposition to their civilian values.

The taking of a life itself may cause ethical and moral conflicts for a service member. To complicate these conflicts further, unanticipated consequences may occur when a service member fires at an enemy combatant. This includes the killing of innocent civilians that may be used by enemy combatants as bait, shields, or fighters. For instance, in speaking of his decision to kill a thirteen-year-old child, who was carrying an assault rifle, a Marine stated,

We just collected up that weapon and kept moving [. . .] He was just a kid. But I'm sorry, I'm trying not to get shot and I don't want any of my brothers getting hurt, so when you are put in that kind of

⁵² Eric Young, *Leadership When Handling Our Fallen Marines*, MARINE CORPS GAZETTE (Jan. 2007).

⁵³ Peter Marin, *Living in Moral Pain*, PSYCHOL. TODAY 68 (Nov. 1981).

situation . . . it's shitty that you have to, like . . . shoot him. You know it's wrong. But . . . you have no choice.⁵⁴

Although service members are trained to kill and such action is necessary, this act still may significantly traumatize the soldier. Civilian societal norms equate children with innocence. Thus, the act of killing a child causes a soldier to act in a manner that violates his moral and ethical values to protect those who are innocent. However, in this case the soldier felt that he had no choice but to take this action in order to protect his brothers without a second thought. As this Marine acknowledged, he was trained to suppress emotion in order to continue to accomplish the mission. In this case, the Marine gathered the weapon from the dead child, without a second thought, and kept going in order to continue the mission. This is vastly different than civilians who experience traumatic events, as their course of treatment often entails a recovery environment where safety is restored in order to begin a healing process.⁵⁵

ii. *The Unique Stressors of Guerilla Warfare and Insurgency*

The characteristics unique to each tour may subject soldiers to an array of unique set of stressors. Recently, most military conflicts include guerilla warfare and insurgent activities. Insurgency is a form of conflict within a state, where a non-ruling group attempts to destroy, reform, or degrade the support of the state's current ruling group in order to effect political change.⁵⁶ Insurgencies utilize propaganda, intimidation through terror, and assassination tactics in order to accomplish their goal.⁵⁷ Insurgencies previously have originated in settings such as trackless deserts, dense jungles, or urban settings, which are less familiar to an opposing state or

⁵⁴ David Wood, *The Grunts: Damned If They Kill, Damned If They Don't*, THE HUFFINGTON POST (Mar. 18, 2014), <http://projects.huffingtonpost.com/projects/moral-injury/the-grunts> .

⁵⁵ Tramontin, *supra* note 7, at 34.

⁵⁶ *Insurgency* in THE ENCYCLOPEDIA OF POLITICAL SCIENCE (George Thomas Kurian ed., 2011) [hereinafter "*Insurgency*"].

⁵⁷ *Id.*

international forces.⁵⁸ This setting provides a strategic advantage to the insurgents.⁵⁹ Guerillas are a small groups, who fight against a larger and more superior force by waging surprise attacks through deception and ambush.⁶⁰

Under these conditions of war, the front lines are not clearly defined. This forces service members to be constantly vigilant in preparation for an unexpected attack or the presence of an improvised explosive device.⁶¹ This heightened level of alertness increases the chances of survival. Given the nature of this type of conflict, service members may be faced with the difficult task of distinguishing an enemy from a civilian.⁶² When faced with only moments to make this decision, a soldier generally errs on the side of caution in order to protect his unit. This may result in the killing of innocent civilians. As discussed above, this action may be deeply traumatizing to the soldier. This trauma is unique to a soldier's experience in a warzone as these are circumstances that civilians are not trained to endure and do not generally endure.

C. Unique Stressors of Post-Deployment

Once soldiers return home, exposure to unique stressors do not cease. In the post-deployment phase, soldiers face a broad range of long-term challenges as they readjust after the experience of war. Due to the nature of battle and focus upon survival, soldiers may not realize the emotional reality of severely traumatic events until their return home. Upon reaching this realization, service members may find it difficult to share the details of their unique experiences with their families as in the battlefield their unique experience was only understood and shared among their brothers.⁶³

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ ANTHONY J. JOES, GUERRILLA WARFARE: A HISTORICAL, BIOGRAPHICAL AND BIBLIOGRAPHICAL SOURCEBOOK 6–7 (1996).

⁶¹ Stressor Determinations for Posttraumatic Stress Disorder, 74 Fed. Reg. 42617, 42618 (Aug. 24, 2009) (codified at 38 C.F.R. pt. 3).

⁶² *Id.*

⁶³ Tramontin, *supra* note 7, at 32.

In reflecting upon this experience, a service member stated, “the only people you can really talk to about the experiences on Operational tour are the people you were with.”⁶⁴

Soldiers often feel that the “civilian world” is unable to understand the unique experiences that they faced in combat.⁶⁵ The support network of brothers logistically decreases once soldiers return from combat as they no longer spend every waking moment sharing the experience and trauma of war together. One service member stated,

You got so used to being around everybody, and now suddenly you are on your own, with nothing to do, and you do, although you try your hardest, you do just get lazy and stop going for runs and things like that.⁶⁶

This adjustment may be extremely difficult because soldiers are taught from the beginning of basic training that they must rely, trust, and protect their fellow service members. Their training focused upon the uniform integration of service members’ identity with their unit. However, once they return, this overwhelming structure of group identity is not as predominant in their daily life.

i. Post-Deployment Impact on Service Members & Their Family

Deployment changes a service member’s family dynamic.⁶⁷ Many families struggle to adjust to the psychological changes of post-deployment of service members.⁶⁸ Although couples are excited to reunite after deployment, they may unexpectedly realize that they require significant time to re-establish physical and emotional intimacy.⁶⁹ This may lead to conflict derived from the sense of disappointment between couples as they expected to resume their relationship where they

⁶⁴ Anna Verey & Peter K. Smith, *Post-combat adjustment: understanding transition*, 4 J. AGGRESSION CONFLICT PEACE RES. 226, 230 (2012).

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ Ronald C. Kessler, *Posttraumatic stress disorder: the burden to the individual and to society*, 61 J. CLINICAL PSYCHIATRY 4 (2000).

⁶⁸ Shelley A. Riggs & David S. Riggs, *Risk and Resilience in Military Families Experiencing Deployment: The Role of the Family Attachment Network*, 25 J. FAMILY PSYCHOL. 675 (2011).

⁶⁹ Tramontin, *supra* note 7, at 32.

left off.⁷⁰ Each of these experiences causes stressors that are unique to service members in the post-deployment stage.

III. Discriminatory and Unreasonable Denial of Benefits to Veterans

In order to receive disability compensation and benefits for PTSD, service members must navigate a two-level system within the United States Department of Veterans Affairs (“VA”) system. First, service members are required to obtain a medical diagnosis from the Veterans Health Administration (“VHA”), which is an obstacle in itself as many military doctors are pressured to misdiagnose PTSD.⁷¹ Upon obtaining a diagnosis, service members then pursue disability compensation through the Veterans Benefit Administration (“VBA”).⁷² The VHA provides medical care to veterans, whereas; the VBA manages the Compensation and Pension Program for the VA. This program handles all claims processing, and scheduling evaluations, to compensate veterans for occupational losses experienced due to a disability suffered during duty.⁷³

Section 38 of the United States Code of Federal Regulations allows for those who serve in the United States Armed Forces to receive disability compensation after returning home from war. Section 38 includes specific criteria for diagnosis. In order to receive disability compensation for PTSD, soldiers must provide (1) a current medical diagnosis of PTSD; (2) a “nexus” of medical

⁷⁰ *Id.*

⁷¹ Bryan A. Liang & Mark S. Boyd, *Defense Policy: PTSD in Returning Wounded Warriors: Ensuring Medically Appropriate Evaluation and Legal Representation Through Legislative Reform*, 22 STAN. L. & POL'Y REV. 177, 178 (2011).

⁷² *Id.*

⁷³ 38 U.S.C. § 1155.

evidence showing a link between the PTSD symptoms and the traumatic event; (3) an in-service stressor;⁷⁴ and (4) credible supporting evidence that the claimed in-service stressor occurred.⁷⁵

A. The Struggle to Obtain a PTSD Diagnosis

In order to diagnose an individual with PTSD, the diagnosis must conform to the DSM-5 criteria.⁷⁶ A diagnosis of PTSD must be supported by the findings of a medical examination and its subsequent report.⁷⁷ An adequate medical examination, which is referred to as a compensation and pension examination, must be based upon consideration of the veteran's prior medical history as well as previous and current examinations. Its' purpose is to determine whether the veteran's disability is connected to military service. Following an examination, a report must be issued that contains clear conclusions, which are supported by data as well as a reasoned medical explanation that connects the disability to the conclusion.⁷⁸

Civilian psychiatrists have a single ethical duty to their individual patient. However, military psychiatrists have a potentially conflicting dual duty to both their patients and to the overall goals of the military. The military seeks to minimize mental health care costs and maximize overall fighting strength and capacity of its troops. The nature of these competing agendas prevents military psychiatrists from adequately diagnosing and treating service members.

⁷⁴ Note: This nexus medical evidence must be supplied by someone who is qualified to give medical diagnoses and must demonstrate that the stressor contributed to PTSD symptoms. This prong is not further discussed herein because in cases where evidence toward this prong is balanced, the benefit of the doubt goes to the veteran. 38 U.S.C. § 5107(b); 38 C.F.R. § 3.102.

⁷⁵ 38 C.F.R. § 3.303(a).

⁷⁶ Note: The VA maintains that the transition from its acceptance of the DSM-IV diagnostic criteria to the DSM-5 diagnostic criteria does not "present a change in how mental disorders are evaluated under the [rating schedule], nor were any disorders removed" from the schedule. Schedule for Rating Disabilities--Mental Disorders and Definition of Psychosis for Certain VA Purposes, 80 Fed. Reg. 14308, 14308–14309 (Mar. 19, 2015) (codified at 38 CFR 4.125(a)).

⁷⁷ 38 C.F.R. § 4.125 (a) (as amended by Schedule for Rating Disabilities–Mental Disorders and Definition of Psychosis for Certain VA Purposes, 79 Fed. Reg. 45093 (Aug. 4, 2014)).

⁷⁸ *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, 301 (2008).

To further complicate this matter, the nature of the patient-doctor relationship is explicitly undermined by military policy. For example, before seeking mental health assistance, service members must sign a vague waiver that explains that conversations with their therapist might not be kept confidential if they admit to violating military laws.⁷⁹ This violation includes both major violations as well as minor infractions.⁸⁰ Kaye Baron, a psychologist who has been treating soldiers from Fort Carson, Colorado stated, “You can find an exception to confidentiality in pretty much anything one would discuss.”⁸¹ This fear of prosecution may prevent service members from opening up in discussions with their doctors. Thus, given these competing agendas, which are created by institutional pressures military psychiatrists are unable to adequately treat and diagnose service members.

This conflict among the dual ethical duties of military psychiatrists is apparent during military service as well as after service is complete. During service, Military Mental Health Officers aim to ensure that these service members are psychiatrically fit to fulfill mission requirements.⁸² In order to maximize the military’s fighting strength, clinicians must carefully weigh medical decisions that keep service members from deploying.⁸³ Thus, Military Mental Health Officers struggle with competing ethical duties as they are required to balance the mission requirements and goals of the military with the best interest of the patient.⁸⁴ Even if a Military Mental Health Officer diagnoses a service member with PTSD, this diagnosis can be overruled by commanders who determine there is a more dire need for the soldier in the field.⁸⁵ This conflicting

⁷⁹ James Dao & Dan Frosch, *Military Rules Said to Hinder Therapy*, THE NEW YORK TIMES (Dec. 6, 2009), <http://www.nytimes.com/2009/12/07/us/07therapists.html>.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² Cozza, *supra* note 41, at 15–18.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Benedict Carey et al., *Painful Stories Take a Toll on Military Therapists*, THE NEW YORK TIMES (Nov. 7, 2009), <http://www.nytimes.com/2009/11/08/us/08stress.html>.

agenda encourages Military Mental Health Officers to ignore symptoms of PTSD in order to support the overall mission of the military .

The competing duties of military doctors do not cease upon a soldier's completion of service. A diagnosis of PTSD obligates the military to provide expensive, intensive long-term care as well as the potential of lifetime disability payments. In light of this overwhelming cost, the military pressures its doctors either to (1) not diagnose, or (2) misdiagnosis symptoms of PTSD under a less costly diagnosis. Dr. Douglas McNinch, a civilian psychologist working for the United States Army, stated to a Sargent,

I will tell you something confidentially that I would have to deny if it were ever public. Not only myself, but all the clinicians up here are being pressured to not diagnose PTSD I and other [doctors] are under a lot of pressure to not diagnose PTSD. It's not fair. I think it's a horrible way to treat soldiers, but unfortunately, you know, now the VA is jumping on board.⁸⁶

Dr. McNinch's experience is not isolated. Other practitioners have also been pressured to put the goal and agenda of the military over the well-being of their patients. For instance, Norma Perez, the PTSD Coordinator at the Central Texas Veterans Health Care System, stated the following in an e-mail to staff psychiatrists,

Given that we are having more and more compensation seeking veterans, I'd like to suggest that you refrain from giving a diagnosis of PTSD straight out [instead] consider a diagnosis of Adjustment Disorder.⁸⁷

Under the DSM, a diagnosis for Adjustment Disorder is appropriate when an individual's response to an extreme stressor does not meet the full criteria for PTSD.⁸⁸ A veteran that receives a diagnosis

⁸⁶ Michael De Yoanna & Mark Benjamin, "I am under a lot of pressure to not diagnose PTSD", SALON.COM (Apr. 8, 2009), <http://www.salon.com/2009/04/08/tape/>.

⁸⁷ Christopher Lee, "Official Urged Fewer Diagnoses of PTSD," THE WASHINGTON POST (May 16, 2008), <http://www.washingtonpost.com/wp-dyn/content/article/2008/05/15/AR2008051503533.html>.

⁸⁸ DSM-5 at §309; Am. Psychiatric Ass'n., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000).

of Adjustment Disorder, is generally not entitled to nearly the same level of compensation and benefits as a veteran that is diagnosed with PTSD.⁸⁹ Ultimately, given the subjective nature of mental health evaluations, a diagnosis of Adjustment Disorder may potentially be misused as a catch-all for symptoms that warrant a PTSD diagnosis. Norma Perez's e-mail is disconcerting as it clearly advocates for an overarching politically-infused military agenda, which is to minimize the cost of war rather than to provide adequate treatment and compensation to service members and veterans that struggle with PTSD.

From a patient's perspective, this negative outcome undermines the quality of care received and discourages soldiers from seeking treatment. For instance, Staff Sgt. Eric James, an Army sniper who served two tours in Iraq, sought counseling from military doctors over his suicidal intentions. Staff Sgt. James was told by his military doctors that

It is truly an injustice that the standard for a soldier must be "in a corner rocking back and forth and drooling" in order to even receive acknowledgement of a struggle with a mental health issue.⁹⁰

It is easiest to dismiss issues and symptoms that are not readily apparent. Since mental health issues vastly increase the cost of the Iraq War, they may be dismissed because mental health issues are not usually readily apparent.⁹¹

The Army's own investigative report admitted to finding "potential systemic pressures" that "may lead providers to avoid making a diagnosis of PTSD . . . contrary to their clinical judgment."⁹² Although this investigative report was published in 2009, this systemic pressure appears to continue influencing the diagnosis of PTSD. In July 2014, a Veteran, who served in Beirut, was

⁸⁹ Lee, *supra* note 87.

⁹⁰ Michael De Yoanna & Mark Benjamin, *supra* note 86.

⁹¹ *Id.*

⁹² *Id.*

denied a diagnosis of PTSD because “seeing debris and [death], but without enemy contact or a life-threatening event, did not meet [DSM-5] Criterion A for PTSD.”⁹³ Criterion A addresses exposure to the stressor that precipitates PTSD. Under Criterion A(4), this stressor may include “repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse).”⁹⁴ Under these circumstances this veteran arguably experienced sufficient exposure to a stressor. However even in light of this, the veteran was unfairly denied a diagnosis of PTSD.

B. The Struggle to Present Credible Evidence of an In-Service Stressor

Once a veteran receives a diagnosis of PTSD, the uphill battle to receive compensation continues. A diagnosis of PTSD does not alone verify the occurrence of the claimed in-service stressor because the Board of Veterans Appeals is not required to grant an in-service connection even if a health professional has determined the veteran’s claim to be credible.⁹⁵ In order to obtain disability compensation, the soldier must present credible evidence that supports the veteran’s current account of the in-service stressors. Whether the stressor is sufficient to support a diagnosis of PTSD is a question of fact that is determined by medical professionals. However, whether the evidence presented establishes the occurrence of an in-service stressor is a question of fact that is determined by adjudicators.⁹⁶

⁹³ Bd. Vet. App. 1630263 (July 28, 2016) (noting that the Veteran met all other criteria for a PTSD diagnosis.).

⁹⁴ DSM-5 at § 309.81(A).

⁹⁵ Cohen v. Brown, 10 Vet. App. 128, 142 (U.S. 1997); Moreau v. Brown, 9 Vet. App. 389, 395–96 (U.S. 1996) (explaining an opinion by a medical health professional based on post-service examination of a veteran cannot be used to establish the occurrence of a stressor).

⁹⁶ Wilson v. Derwinski, 2 Vet. App. 614, 618 (U.S. 1992); Bd. Vet. App. 16-28606 (July 19, 2016).

The VA utilizes a two track approach in evaluating the credibility of evidence in regards to this prong. The definition of combat versus noncombat roles may potentially play a critical role in the issuance of veterans' disability benefit claims. The first track pertains to veterans whose records reflect evidence that they "engaged in combat with the enemy."⁹⁷ Combat Veterans are provided a lower evidentiary burden to establish the occurrence of a stressor. To qualify for this track, the soldier must have participated in an actual fight or encounter with a military foe, hostile unit, or instrumentality. This qualification is determined on a case-by-case basis.⁹⁸ The qualifying criteria excludes situations where personal harm was a definite possibility due to imminent enemy action, but the service member was not directly fired upon or did not fire upon the enemy.⁹⁹ Additionally, a showing of "no more than service in a general 'combat area' or 'combat zone' [is] not sufficient to trigger evidentiary [standard that pertains to service member who engaged in combat]."¹⁰⁰ Thus, many Veterans who endure a Combat environment are not designated as Combat Veteran and are subjected to a higher evidentiary burden to establish the occurrence of a stressor.

i. Combat Veterans

As discussed above, combat veterans that "engaged in combat with the enemy" are provided a lower evidentiary burden to establish the occurrence of a stressor.¹⁰¹ Accordingly, if it is established that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, lay evidence may serve as sufficient proof of service connection when evidence is

⁹⁷ 38 C.F.R. § 3.304(f).

⁹⁸ Peake, *supra* note 12, at 1158.

⁹⁹ *Sizemore v. Principi*, 18 Vet. App. 264, 272 (U.S. 2004) (holding that the Board erred in finding that the veteran did not engage in combat simply because he did not receive fire from the enemy).

¹⁰⁰ Peake, *supra* note 12, at 1158.

¹⁰¹ 38 U.S.C. § 1154.

consistent with the circumstances of service but unverifiable through an official service record.¹⁰² Lay evidence includes statements from the veteran's family, friends, work supervisors, and co-workers.¹⁰³ Although lay evidence may be refuted through expert medical evidence, combat veterans are provided a significant advantage as to the evidentiary standard when attempting to prove the presence of a service stressor. This favorable treatment is provided to veterans because, given the turbulent nature of combat situations, verifiable records may be deficient as such records may not have been created, may have been destroyed, or may be incomplete.¹⁰⁴ Thus, if combat veterans describe through lay testimony the traumatic events underlying their PTSD, a rebuttable presumption arises that those events occurred, even if official records contain no reference to the events.¹⁰⁵ Thus, this stressor is considered "verified" by veterans' testimony alone.

ii. Non-Combat Veterans

When veterans are unable to establish that they "engaged in combat with the enemy," they are subjected to a higher evidentiary standard. Unlike combat veterans on the first track, a non-combat veteran on this track does not receive the benefit of a presumption to establish the credibility of the veteran's evidence of exposure to the requisite stressor. Thus, a veteran's testimony alone cannot sufficiently establish the occurrence of a non-combat stressor.¹⁰⁶ Therefore, non-combat veterans are faced with a higher evidentiary standard to succeed in a disability claim.¹⁰⁷ This is problematic because military records non-combat veterans are also often incomplete, outdated, or destroyed.

¹⁰²*Id.*; 38 C.F.R. § 3.304(f)(2).

¹⁰³ Hillary A. Wandler, *The Role of Culture in Advocating for Accurate Diagnosis and Rating of Veterans' Psychological Disabilities*, 2 MENTAL HEALTH L. & POL'Y J. 1, 14 (2013).

¹⁰⁴ See S. Rep. No. 77-902, at 2 (1941); H.R. Rep. No. 77-1157 at 2-3 (1941); *Arms v. West*, 12 Vet. App. 188, 197 (U.S. 1999); *Dambach v. Gober*, 223 F.3d 1376, 1380 (Fed. Cir. 2000).

¹⁰⁵ 38 U.S.C. § 1154(b).

¹⁰⁶ *Dizoglio v. Brown*, 9 Vet. App. 163, 166 (U.S. 1996).

¹⁰⁷ *Cohen v. Brown*, 10 Vet. App. 128, 134 (U.S. 1997).

In one instance, a non-combat veteran reported that he witnessed an accident during service, in which a military truck struck a family in Germany resulting in the death of an infant.¹⁰⁸ However, the Board of Veterans Appeals determined this incident was not related to either combat or fear of hostile military or terrorist activity.¹⁰⁹ Therefore, the veteran's assertions were insufficient to verify a non-combat stressor.¹¹⁰ The nature of this stressor clearly appears to be related to the veteran's service. However, without a presumption of the occurrence of the stressor, this veteran was unable to establish the presence of this stressor in order to obtain benefits and compensation for his PTSD.

In another instance, a veteran who conducted patrols through Beirut during his deployment witnessed numerous bodies of individuals previously killed by sniper fire. This was also deemed a "non-combat situation."¹¹¹ The nature of this stressor clearly appears to be related to the veteran's service in a combat zone. However, this veteran was also denied the ability to present lay testimony in order to establish the presence of this in-service stressor.

This distinction between combat and non-combat is arbitrary. It is illogical to distinguish between those who experience active fire in traditional combat roles and those who witness the same horrific conditions of combat after fire has ceased. Both individuals experience significant trauma. Therefore, this heightened evidentiary standard significantly hinders a non-combat veterans' likelihood of success as it is difficult to present credible evidence of an in-service stressor outside of lay testimony.¹¹² Thus, both combat and non-combat veterans should be provided the same evidentiary standard.

¹⁰⁸ Bd. Vet. App. 1626935 (July 28, 2016).

¹⁰⁹ *Id.* at 6.

¹¹⁰ *Id.*

¹¹¹ Bd. Vet. App. 1630263, at 4 (July 28, 2016).

¹¹² Bd. Vet. App. 1626935, at 6 (July 6, 2016).

1. *2008 Relaxed Standard for Service Members' Diagnosis While In-Service.*

In 2008, veterans who were diagnosed with PTSD while still in service and who suffered from a stressor that occurred during the period of service were allowed to establish evidence of the stressor through lay testimony in a similar manner as combat veterans.¹¹³ However, as discussed above, receiving a diagnosis of PTSD while during service is a difficult task given the competing ethical duties of military psychiatrists. Thus, this relaxed standard does not resolve the major barriers encountered by those non-combat veterans. Furthermore, the 2008 relaxed standard does not encompass non-combat veterans whose symptoms arise after completion of service. Thus, many veterans are improperly denied much needed PTSD compensation.

2. *2010 Amendment: Fear of Hostile Military or Terrorist Activity*

In July 2010, the definition of stressors was expanded to include fear of hostile military or terrorist activity if (1) a VA psychiatrist or psychologist, or contract equivalent, confirms that the claimed stressor is adequate to support a diagnosis of PTSD; (2) the veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary; and (3) the claimed stressor must be consistent with the places, types, and circumstances of that veteran's service.¹¹⁴ Fear of hostile military or terrorist activity means that a veteran experienced, witnessed, or was confronted with actual death, threatened death, serious injury, or a threat to the veteran's physical integrity.¹¹⁵ This fear may be attributed to an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade;

¹¹³ 38 C.F.R. § 3.304(f)(1) (2016).

¹¹⁴ *Id.* §3.304(f)(3).

¹¹⁵ *Id.*

small arms fire, including suspected sniper fire; or attack upon friendly military aircraft.¹¹⁶ It may also encompass a veteran's response to circumstances that involved fear, helplessness, or horror.¹¹⁷

This expanded definition of stressors recognizes experiences that frequently occur when service members face Guerilla Warfare and Insurgency Activity. Thus, this is a progressive step forward as it addresses the nature of modern conflicts. This also allows the VA to begin to recognize the occurrence of trauma in "military personnel who are deployed to war zones and who, although not assigned to or engaging in actual front-line combat, nonetheless are faced with significant combat-like stressors in an era of increased insurgent and guerilla warfare."¹¹⁸

However, this Amendment may continue to prevent veterans with PTSD from obtaining proper benefits and compensation. As previously discussed, military mental health professionals are under pressure to misdiagnose and inadequately diagnose PTSD. This Amendment places greater weight on the opinion of the VA mental health evaluator, thus the internal pressure may continue to serve as a barrier to veterans, who seek to obtain benefits and care.

IV. Victims or Warriors?

The qualities of bravery and selflessness are instilled in service members through their unique training and experiences. In reflecting upon this concept, a United States Army Brigadier General stated,

The life and death nature of what we do as soldiers is what draws us together and creates the unique cohesion of the bands of brothers [. . .] which simply do not exist anywhere outside military experience. Skill, trust, shared sacrifice, and even fear bind warriors together so tightly that they are capable of acts of courage [. . .] At the core of the willingness to kill and die for one another is

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Acevedo v. Shinseki*, 25 Vet. App. 286, 292 (U.S. 2012).

trust bound up in shared sacrifices [. . .] it sets us apart from all other [professions].¹¹⁹

Service members routinely risk their lives for their brothers and for our nation. Implications of war heroism are commonly reflected in legislative bills regarding PTSD.¹²⁰ This includes “Heroes at Home Act of 2007,” “Healthier Heroes Act,” “Healing Our Nation's Heroes Act of 2008,” “Wounded Heroes’ Bill of Rights Act,” and “Homecoming Enhancement Research and Oversight (HERO) Act[s].”¹²¹ The titles of these bills reflect our societal view of service members as brave warriors.

The concept of being a victim of a mental health issue is in direct conflict with the stereotypical ideas and cultural perceptions of strong, heroic warriors. Victims are often viewed as weak. Therefore, service members who identify with mental health issues are stigmatized as weak. This is an image that also is in direct opposition to their initial motivation to enlist in the military — to improve their social standing. The idea of seeking help for mental health issues is further stigmatized by their brothers. One Marine stated, “you might as well just lie down and cry for your mommy if you go for mental health services.”¹²² As previously discussed, in basic training service members separated from their individual identities and instead are taught to identify with their membership within the unit. Their values and ideas are dictated by those of the unit. Service members earn respect of their peers by identifying with the overall values and attitudes of the unit. Thus, the peer-pressure within the unit that stigmatizes PTSD symptoms is problematic as it prevents soldiers from seeking help.

¹¹⁹ Sean Macfarland, *Fight, Kill, Die, Buddy: Words Professional Soldiers Live By*, MILITARY REVIEW, (Sept. 29, 2011) http://usacac.army.mil/CAC2/MilitaryReview/Archives/English/MilitaryReview_20110930PofA_art013.pdf.

¹²⁰ Jonathan Purtle, “*Heroes’ Invisible Wounds of War: Constructions of Posttraumatic Stress Disorder in the Text of US Federal Legislation*,” 149 SOC. SCI. MED. 9 (Jan. 2016).

¹²¹ *Id.*

¹²² Tramontin, *supra* note 7, at 29.

In addition to stigmatization within the military, civilians also criticize service members for seeking benefits and compensation. One skeptic of PTSD, Sally Satel, stated,

Imagine a young soldier wounded in Afghanistan. His physical injuries heal, but his mind remains tormented. Sudden noises make him jump out of his body. He is flooded by nightmares, can barely concentrate, and feels emotionally detached from everything and everybody. At 23 years old, the soldier is about to discharge from the military. Fearing he'll never be able to hold a job or fully function in society he applies for "total" disability (the maximum designation, which provides roughly \$2,300 per month) compensation for PTSD from the VA. This soldier has resigned himself to a life of chronic mental illness.¹²³

This dangerous rhetoric further stigmatizes PTSD, discourages soldiers from seeking help, and invalidates legitimate symptoms.

Sally Satel is not the only critic that disseminates this dangerous rhetoric. Martha Leatherman states that if veterans are told their symptoms meet the criteria for PTSD, "[t]his stirs up visions of Vietnam veterans living under bridges... and then, in a panic they apply for disability compensation for PTSD so they will not end up homeless too."¹²⁴ This rhetoric also further perpetuates the stigma surrounding PTSD. Additionally, it discourages veterans from seeking needed help as it paints those who apply for compensation as weak cowards, who seek compensation for an invalid problem. The undertone of these statements urge veterans to "man up." However, in contrast to this toxic rhetoric, the strongest warriors seek help against military and social norms that deter them from taking such action.

V. *Separate Diagnostic Criteria for Unique Military Stress and Trauma*

In order to further provide adequate benefits to veterans and relieve the stigma, separate diagnostic criteria of combat stress should be tailored around the unique experiences of service members and veterans. Ironically, PTSD historically developed from the notion of combat stress,

¹²³ Sally Satel, *PTSD's Diagnostic Trap*, 165 POL'Y REV. 41, 48 (2011).

¹²⁴ *Id.* at 51 (quoting Martha Leatherman).

which is a concept as old as war itself. During World War I, the term “Shell Shock” was used to characterize soldiers who were dazed, nervous, and disoriented after exposure to exploding artillery shells.¹²⁵ Whereas, during World War II, similar symptoms were referred to as combat exhaustion.¹²⁶ The first edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM”) justified a diagnosis for Gross Stress Reaction only when an individual was exposed to either severe physical demands or extreme emotional stress like that experienced in combat.¹²⁷ The second edition of the DSM included a diagnosis for Adjustment Reaction of Adult Life, which specifically addressed combat stress.¹²⁸ PTSD was first formally recognized by its’ current name in the third edition of the DSM, which noted that traumatic experiences may be experienced within the company of a group of people such as those specifically involved in military combat.¹²⁹ Thus, the historical evolution of PTSD has been tied to the concept of combat stress.

Even in light of the historical evolution of the diagnosis of PTSD, the current DSM-5 diagnostic criteria generalizes combat stress and the trauma of service members along with other types of trauma experienced by civilians. Through basic training, service members are taught to transform themselves from their prior civilian identities into members of a military unit. The unique experiences of this training and its aftermath, are significantly different than the experiences of civilians. Given their unique training, service members do not perceive their experiences in the same manner as civilians. After training, service members undergo a unique cycle of deployment. This is an experience and combination of stressors that is not equivalent to

¹²⁵ Charles S. Myers, *A Contribution to the Study of Shell Shock.: Being an Account of Three Cases of Loss of Memory, Vision, Smell, and Taste, Admitted into the Duchess of Westminster’s War Hospital, Le Touquet*, 185 THE LANCET 316 (1915).

¹²⁶ Army Service Forces Office of the Surgeon General, *Nomenclature of Psychiatric Disorders and Reactions*, WAR DEP’T TECHNICAL BULLETIN: MEDICAL 203 (1946).

¹²⁷ Am. Psychiatric Ass’n., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 40 (1st ed. 1952).

¹²⁸ Am. Psychiatric Ass’n., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 49 (2d ed. 1968).

¹²⁹ Am. Psychiatric Ass’n., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 236 (3d ed. 1980).

those of civilian life. Thus, it is illogical to diagnose service member and veterans with the same generalized criteria that evaluates the traumatic experiences of civilians.

Specialized diagnostic criteria directly targeted at the unique experiences and training of military service members would more adequately address the issues of combat stress and trauma. This specialized diagnostic criteria would also help to reduce the stigma faced by those who seek help for combat stress and trauma because seeking help might be seen more as “par for the course” rather than a weakness within a warrior. This influence upon norms has enormous far-reaching potential as this diagnosis becomes more readily accepted it would drive change. It would allow a larger number of service members to feel comfortable seeking assistance without the fear of scrutiny from fellow service members. This influence would also change societal views of service members who do seek benefits and compensation in order to combat the dangerous rhetoric that perpetuates the stigma surrounding combat related trauma. This change in norms would additionally drive policy change in decisions to award benefits and compensation to veterans as the necessity for benefits and compensation would be directly linked to the cost of war. Thus, the development of specialized diagnostic criteria for those who experience combat related stress and trauma has vast societal benefits.