MISSION COMPLETION, TROOP WELFARE AND DESTRUCTIVE IDEALISM: A CASE STUDY ON THE PHENOMENOLOGY OF A COMBAT VETERAN'S SOCIAL REINTEGRATION

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ABSTRACT

Post-traumatic Stress Disorder (PTSD) among combat veterans remains an urgent and intractable problem for those who have served in the wars in Iraq and Afghanistan. In this paper, we argue that one of the reasons that combat related PTSD remains so difficult to treat is because psychologists - and American culture at large - do not fully understand it yet. It is our contention that there are two contributing factors that currently hinder our ability to successfully treat combat related PTSD. The first is a failure to look critically at the theoretical underpinnings that ground our current understanding of the disorder. The second related issue is our tendency to look to reductionist explanations and treatments. We use the theoretical framework of phenomenology alongside a case study of a man we call James in order to present this argument.

Keywords: Trauma, PTSD, Combat Trauma, Phenomenology, Social Reintegration, Idealism, Goal Orientation

INTRODUCTION

Post-traumatic Stress Disorder (PTSD) was officially designated as a mental disorder in 1980. Though this classification has existed for over thirty years, it has gained significant media attention and press over the past ten years. This is due, at least in part, to the staggering numbers of veterans returning from Iraq and Afghanistan being diagnosed with PTSD (The National Center for PTSD). Regarding American military veterans, it is not just the increase in diagnoses that is of concern, but the refractory nature of the disorder. Since 2007, Congress has appropriated upwards of 1.5 billion dollars to help improve the prevention, diagnosis, and treatment of PTSD. Despite these efforts, veteran rates of suicide remain alarmingly high. Current reports on suicide data estimate that 22 veterans commit suicide every day, a statistic that is cited often. What many people do not know is that these current reports do not include veterans who have been dishonourably discharged, nor those who are active service members, nor those who die by overdose, nor the deaths that occur in Texas and California as these states have not provided data.[1] There is significant reason then, to think that the actual number of suicides due to military related PTSD is much higher than 22 people a day.

Despite these alarming statistics, research reveals divergent findings from the psychological community at large. When researching the current state of the APA relative to veterans, one is likely to find a resounding level of certainty when it comes to understanding and treating this population. There is much talk about "evidence-based" interventions, as well as a general feeling of optimism regarding the efficacy of treatment options for combat veterans who suffer from PTSD. Part of this optimism is due to the much-heralded usage of a particular theoretical understanding of combat trauma and a corresponding form of treatment.

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[1] See Janet Kemp and Robert Bossarte, "Suicide Data Report, 2012," Department of Veterans Affairs Mental Health Services Suicide Prevention Program (2013), http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf. See also Janet Kemp, "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and Other Veterans through 2010," Veterans Health Administration (2014). http://www.mentalhealth.va.gov/docs/Suicide_Data_Report_Update_January_2014.pdf.

BACKGROUND

The common theoretical conceptualization of combat trauma can be found in the latest edition of the diagnostic and statistical manual of mental disorders published in 2013 (DSM-V), while the singular most lauded treatment for this disorder at the moment is Prolonged Exposure Therapy (PET), a type of Cognitive Behavioral Therapy (CBT). In the DSM-V, PTSD is classified as an anxiety disorder that occurs when a person is a victim of or spectator to a traumatic event (i.e., unexpected death, violence, brutality, aggression, sexual assault, natural disaster, car accident, etc.). In order to be diagnosed with PTSD, a patient has to presently manifest a series of symptoms from each of the four clusters specified in the DSM, including intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. These symptoms also must be measured relative to the duration of these symptoms in arousal and reactivity (DSM-V, 2013). Ultimately, when an individual is diagnosed with PTSD, they are presumed to be the witness of an unexpected, tragic, life-threatening, or shocking event. The experience of such an event, as well as the unexpected nature of it, is what gives rise to some range of these physiological, psychological, and somatic symptoms that occur over an extended period of time.

One widely accepted form of therapy for the treatment of combat related PTSD is PET, which – as mentioned above – falls under the umbrella of CBT. CBT is itself a complicated technique, marrying both theory and practice from cognitive and behavioral theories of psychology. In short, CBT can employ both cognitive (i.e., thought reappraisal) and behavioral (i.e., problem-solving action, reinforcement and deterrent techniques) interventions *or* it can rely more heavily on just one of these approaches. Some commonly applied uses of CBT include mental reframing techniques, de-catastrophizing techniques, goal setting, behavioral self-experiments, keeping thought records and journaling, and – in the case of PET - prolonged exposure to aspects of the initial stressor that caused the trauma (Craske, 2010). In short, the theoretical foundation of CBT when applied to a patient diagnosed with PTSD is that the impact of the trauma has taken effect on the thought-processes, perceptual heuristic, and behavioral tendencies of the victim. Consequently, the cure must involve a reappraisal of these thought processes and, possibly, a reconditioning of the patients' behavioral tendencies.

The theory upon which PET rests is a long-standing concept regarding what is especially disruptive about trauma. Put simply, the idea is that traumatic events result in symptoms because they are not adequately lived-through and categorized when they occur. Psychiatrist Dori Laub, who works primarily with holocaust survivors, holds that traumatic events by nature cannot be registered correctly. He explains, "Massive trauma precludes its registration; the observing and recording mechanisms of the human mind are temporarily knocked out, malfunction" (Laub, 1992, p. 57). Quotidian events can easily be understood, thought through, categorized, and rendered coherent. Tus, traumatic events are disruptive precisely because they stand so far outside the norm. Since they cannot be easily thought through, categorized, or rendered coherent, traumatic events cannot be appropriately placed in the past. Laub argues that traumatic disruption - this temporary shutting down of the recording mechanism of the subject - is alleviated (if it can be alleviated), when the victim is able to narrate the event to an empathic listener(s) (Laub, 1992).

Edna Foa, the founder of PET, argues further that once a fear response is set up in an individual, there is no way of extinguishing the fear response. The result is that each time the memory is triggered, the patient relives the event and the corresponding fear response (e.g. dissociation, hyperarousal, etc.) (Foa, 2011). The only way to get this cycle of trauma to halt is to relive the original event in a therapeutic setting in order to process and intervene in ways that were impossible at the time.

In some circles of the psychological community, praise for PET is resounding. Foa herself cites evidence-based research that proves the efficacy of PET in treating PTSD over other therapeutic methods (Foa, 2011). This evidence-based research has been used to disseminate this therapeutic method widely and PET is often touted as the gold standard for the treatment of PTSD. The United States Department of Veterans Affairs recommends PET to veterans struggling with PTSD, citing its efficacy for veterans in particular. They have even created a mobile app called PE Coach designed to provide further support for veterans undergoing the therapy. Both Foa and the VA minimize possible negative effects of this method. The VA admits that risks are involved with PET, but claims that they are minimal and that, "most people who complete PE find that the benefits outweigh any initial discomfort" (US Department of Veterans Affairs). However, Foa herself is less forthcoming, stating simply "PE is well tolerated by patients

and does not cause long-term exacerbation of symptoms" (Foa, 2011).

Ultimately, it is our contention that this current espousal of PE and CBT by the APA and the VA is problematic for three reasons. First, empirical data does *not* give as favorable an assessment of PET as Foa and the VA lead one to believe. In fact, there is an alarming amount of data showing the dangers inherent to this method, including high dropout rates up to 40%. Second, we argue that the claims made about this therapy rely on a therapeutic conceptualization of combat experience that is devastatingly incomplete. To presume that soldiers simply think incorrectly about their combat experiences and/or need to be reconditioned cognitively or behaviourally after combat is too simple a response for such a complicated experience. Finally, upon examining the lived experience of serving as a combat soldier, it is quite possible that the struggles and symptoms soldiers experience upon social reintegration have little or nothing at all to do with what we traditionally imagine as traumatic. In other words, the presumption that the death, violence, or hostility faced in combat are the main causes of struggles and symptoms for soldiers upon reintegrating is an overstatement and, quite possibly in many cases, a red herring.

We will be using phenomenological theory and a case study to illustrate some of the ways in which the lived experience of combat can be misunderstood, as well as how this misunderstanding stands to damage the lives of veterans rather than to help them. To do this, we split the paper into two sections. In the first section, we look at the history of combat trauma and problematic interventions in order to show how easy it is to misunderstand failure for success when methods are housed within limited theoretical frameworks that clinicians are committed to. Next, we examine theoretical conceptualizations of combat that portray the soldier as more than simply a victim of trauma. In the second section of the paper, we analyze a case study conducted with a former combat veteran to give voice to a more complex and nuanced conceptualization of the combat experience. This case study will highlight a range of experiences found in soldiers who have been diagnosed with PTSD upon reintegration but are not experiencing themselves as anxious victims of violent trauma.

It is important to emphasize that we are not denying that the classical understanding of trauma is false or incorrect. Likewise, we are not denying that CBT in general (and PET specifically) can be useful to treat combat related trauma. Rather, we are emphasizing the

importance of looking critically at the theoretical foundations of treatment, the potential misdiagnosis that is being placed on veterans, and highlighting the danger of reducing such a complex sphere of experiences to one singular theoretical explanation and one singular treatment method.

THEORETICAL CONSIDERATIONS

Mistakes from the Past & Bringing Phenomenology Into the Future

In our current situation, we do not have the benefit of hindsight. Sometimes, looking at a parallel from history can throw our current mistakes into relief. In this section, we will briefly look at an example from post-World War I psychology in order to highlight just how distant a therapeutic method can be from its assumed results. After the First World War, soldiers curiously started exhibiting symptoms of hysteria (Van der Hart, Brown, & Graafiand, 1999).[2] Since hysteria was typically reserved for women who had experienced sexual assault in childhood, these soldiers' symptoms posed a classification problem. Rather than find similarities in these psychological states that seemed to result from both combat and sexual assault, theorists instead looked for causal differences. It was thought that the symptoms in soldiers were physiologically based, a result of physical rather than psychological trauma. One such theory gave way to the popular term "shell-shock," i.e., the theory that repetitive exposure to exploding shells caused minor concussions resulting in these hysteria-like symptoms. The theory was tested, and quickly abandoned due to the presence of soldiers who exhibited the symptoms but were not exposed to concussive blasts (Myers, 1915).[3]

In 1922, the British Medical Journal summarized recent findings relating to shellshock. Their research found that:

> "A large number of shell-shock cases in a battalion was a sign of poor morale… a poor morale and a defective training are one of the most important, if not the most important etiological factors: also that shell-shock was a "catching" complaint." (The British Medical

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[2]   Van der Hart, Brown, and Graafiand, "*Trauma-Induced Dissociative Amnesia*," 392-398.

[3]   This term is largely credited to Charles Myers, who wrote about the phenomenon of shell-shock in
"*A Contribution to the Study of Shell-Shock*" in 1915 (The Lancet, February 13, 1915). Myers recants his work in 1919 with another essay in the Lancet called "*The Study of Shell-shock*" (The Lancet, January 11, 1919).

Journal, 1922)[4]

In other words, shell-shock was not physiologically based, nor was it the result of war so much as it was thought to be simply a result of human failure. Many who suffered were assumed to be lazy, exaggerating their symptoms for sympathy. This belief led to treatments that used humiliation and violence to snap soldiers out of their altered states and to turn them back into heroic men.

Lewis Yealland, a Canadian psychiatrist, was a proponent of such treatment. He believed that patients could be brought out of their symptoms through aggressive counter-suggestion. The clinician would either utter provocative statements to the patient, which would elicit an angry response, or surprise him with loud noises, which would shock him out of his silence. If neither of these methods worked, a spatula would be pushed into the back of the throat. The most severe cases were treated by the application of strong electric shocks directly to the throat (Yealland, 1918).

In a case study published in Yealland's "Hysterical Disorders of Warfare," Yealland describes patient A1 as someone whose mutism did not succumb to several types of treatment (Yealland, 1918).5 After nine months of treatment that included electric shocks applied to his throat, cigarettes extinguished on his tongue, and hot plates placed at the back of his throat, patient A1 remained mute. Yealland reports that, in his determination to heal, he told the patient, "You will not leave this room until you are talking as well as you ever did; no, not before... you must behave as the hero I expect you to be" (Yealland, 1918, p. 9). Yealland then applied an electric shock to the throat so strong that it sent the patient reeling backwards, unhooking the battery from the machine. Yealland strapped the patient down and continued to apply shock for an hour, at which point patient A1 finally whispered "Ah." After another hour, the patient began to cry and whispered, "I want a drink of water" (Yealland, 1918, pp. 7-15). Yealland reports this encounter triumphantly. He interpreted this breakthrough to mean that his theory was correct and that his method worked. Further, the success of the theory proved that

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[4]   "Shell-shock," The British Medical Journal 2, no. 3216 (1922): 322-323.

[5]   57 Ibid., 1-30.

shell-shock was a disease of manhood rather than an illness that came from witnessing, being subjected to, and partaking in incredible violence.[6]

In detailing a particularly productive morning, Yealland claims that he treated six mute patients in the space of a half an hour. The first patient responded to loud coughing in his ear, the next to the forcing of a tongue depressor to the back of his throat, the next three to strong electric shocks to their throats; and, "the sixth, on hearing the others fell from a chair, striking his head on the floor, and began to talk" (Yealland, 1918/2009). Yealland thought that he had returned the soldiers to their real state of being when they began to speak in response to his treatment. He believed that brutality was not only justifiable, but a necessary means of reaching the puppet master behind the pathological symptoms. What is perhaps more likely is that the brutal treatment created new and vivid meaning for the soldier: speak now or continue to submit yourself to bodily harm. It is indeed possible that the sixth soldier fell out of his chair, not because the method was so effective, but out of *fear*. What we can see with the benefit of hindsight (but what was perhaps invisible then) is the tight feedback loop that the therapist can get in when his own theory bears out. The hypothesis leads to a method. If the method yields a result, this result is assumed to be causally related to the hypothesis. There is no room here for variance among patients. Those for whom the method did not work were labeled malingers.

Ultimately, though the methods were much more severe than those applied in PET, the conceptualization behind and goal of this therapy shares deep kinship with those applied in PET. Both methods intend to alter the perceptual processes, as well as reshape the thought-processes and behavioral tendencies of the soldier in an effort to make them more resilient in the face of combat trauma. Both also assume a kind of failure on the part of the patient. We should also notice that when the technology fails – because it is seen as *the thing that cures* – the blame

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[6] These treatments of trauma, though thought to be acceptable and effective, were unsurprisingly controversial. For example, in the opening scene of Stanley Kubrick's anti-war film "*Paths of Glory*," a General approaches a dazed soldier and asks him, "Are you ready to kill more Germans?" When the soldier stumbles over his answer, another soldier tries to explain that he's a bit shell-shocked. The General responds, "I beg your pardon, Sergeant, there is no such thing as shell-shock!" He then turns to the first soldier, "Get a grip on yourself, you're acting like a coward. Snap out of it coward! Sergeant, I want you to arrange for the immediate transfer of this baby out of my regiment. I won't have our brave men contaminated by him!" (Stanley Kubrick, Calder Willingham, and Jim Thompson. *Paths of Glory,* directed by Stanley Kubrick [1957; Beverly Hills, CA: Universal Artists, 1999], DVD).

shifts back to the patient. The major shortcoming of this theoretical model lies in the idea that the complex human phenomena of combat trauma can be reduced to a singular explanation, and a singular treatment. Too often in the process of diagnosis for combat veterans who are struggling with an array of symptoms, psychologists and physicians become hungry for a singular diagnostic tool and a correspondingly univocal treatment. Any improvement is seen as *proof* that the method is effective. This perspective is not just myopic, but can expose the patient to unintended consequences just as dangerous as Yealland's violent methods.

Phenomenology throws into question the viability of this kind of reductionism, and gives us another possible explanation through embodiment theory. In his *Phenomenology of Perception*, Merleau-Ponty reconsiders cases like this and argues that these patients are not consciously performing and "acting out" as one might think, rather their consciousness extends through their bodily interaction with the world.

As he explains:

"...the body does not constantly express the modalities of existence in the way that stripes indicate rank, or a house-number a house: the sign here does not only convey its significance, it is filled with it; it is, in a way, what it signifies..."[7]

Under this paradigm, the body is not a puppet responding to orders from the brain, and the real meaning of our actions are not magically revealed when we understand what is going on neurologically. Rather, consciousness and the body coexist in the human being and inform one another. The body does not stand for consciousness; it is a vital *part* of consciousness. When we do not take this into account, we can gravely misunderstand what is going on and misuse the technology. Yealland, and many others, came into treatment carrying the belief that traumatized soldiers were "acting out" – that their bodily symptoms told a story about what was going on internally.

This highlights precisely why we need to be careful when we look for singular explanations of behavior and singular cures for disorders. First, to separate the mind from the body as if they

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[7]   Merleau-Ponty, *Phenomenology of Perception*, 186.

are two distinct entities is to risk missing something important about what it means to exist in the world as an embodied being. Second, when we reduce human phenomena to the necessarily reductive perspective of a scientific explanation, we risk a detrimental oversimplification that can come to bear on treatment. In the best-case scenario, it can result in the reliance on a technological cure that doesn't work, and at worst, it can perpetuate harm.

Re-Conceptualizing the Combat Experience

Though simple confirmation bias can explain how a clinician or group of clinicians can come to rely on treatment methods to the peril of their patients, it does not explain from where these theories arise or how they come to take hold. In order to understand this tendency, one must look more closely at the conceptualizations of combat upon which these theories and treatments are based. As mentioned above, the current conception of veterans is limited and this can impact treatment in significant ways. This section will focus on theory derived from the lived experience of combat, relying on concepts that more fully portray what it is like to be in combat. We focus on two subdivisions of combat experience, first violence and combat arousal and second devotion to troop warfare. We will return to these themes in our case study.

Violence & Combat Arousal

The archetype of the veteran in popular culture leads one to imagine a stoic character that participates in violence unwillingly or unknowingly, with aversion, and then is scarred by the experience of it. He is tortured by the loss of his fellow soldiers, some of whom have died in his arms. To be sure, this is one possible form of experience for the soldier in combat. However, this dramatic and traumatic brush with death is only one of many different experiences a soldier may have with violence and combat. Furthermore, stoic witnessing is not the only way in which the soldier may seek to engage in the behavior of combat. The soldiers' lived experience of violence can even be arousing, fulfilling, and very difficult to replicate upon returning from deployment.

Sebastian Junger provides an illustration that reveals just how the rush of adrenaline, focus, flow, and psychosomatic energy experienced when engaged in combat is unprecedented and difficult to recreate. In his book *War* (2010), Junger references a moment when the lieutenant of a platoon, after five days without a firefight, expresses how he wishes that the platoon would be attacked so that at least there would be *something* to do (Junger, 2010). It seems curious – if not bizarre – that the individual at the helm or protecting a platoon would be

wishing for a firefight. It is worth noting that this only seems curious because it differs from what we expect from the soldier-as-stoic archetype. Nevertheless, this highlights the notion that there was at least an element of combat that was satisfying and sought out among the soldiers. The rush of adrenaline in the combat experience can be satisfying and many soldiers miss the ability to recreate the intensity of this experience when returning to a peaceful, orderly, sage, and civilized world. When platoon member Brendan O'Byrne is asked what he misses most about being in the army and being deployed in a combat zone, he answers politely, "I miss almost everything about it" (Junger, 2014). Ultimately, this answer is only strange in a world in which we hope to label everything that is violent as traumatizing.

Chris Hedges uses psychoanalytic concepts to argue even further that the experience of combat is one in which our innate attraction to death is recognized and activated. For Hedges, the individual instinct to return to violence and face one's own mortality must be acknowledged in order to properly conceptualize human behavior and the readiness so many conjure when they are called into violence. After paraphrasing and quoting from Freud's *Beyond the Pleasure Principle* and *Civilization and its Discontents*, Hedges candidly articulates his own experience with the death drive (*Thanatos*). He writes:

> "We believe in the nobility and self-sacrifice demanded by war, especially when we are blinded by the narcotic of war. We discover in the communal struggle, the shared sense of meaning and purpose, a cause. War fills our spiritual void. I do not miss war, but I miss what it brought. I can never say I was happy in the midst of fighting in El Salvador, or Bosnia, or Kosovo, but I had a sense of purpose, of calling. And this is a quality war shares with love, for we are, in love, also able to choose fealty and self-sacrifice over security." (Hedges, 2002)

For Hedges, the unique manifestation of *Thanatos* in the combat experience is expressed here. The phrase "blinded by the narcotic of war" speaks lucidly to the overwhelming effect on our emotions that this drive can have in the midst of combat. This is a *drive*, and thus our actions are naturally driven. *Thanatos* moves us, beckons us, and directs our behavior in very specific ways toward very specific ends.

Both thinkers alert us to the complexity inherent in the experience of combat violence. After the experience of combat, it can be wildly difficult for a veteran returning to a civilian society to replicate the emotional catharsis, sense of meaning and identity, and interpersonal

connection. This leads to an especially complicated kind of double loss because once the soldier returns home there may be naïve culturally-situated expectations as to what his experience of combat was. The veteran is not allowed to admit that there are variances in the experience of war, that there were different kinds of violence and death, that they participated in them in ways that they could not have expected, that combat was exciting, or that they may find themselves wanting to go back.

Devotion to Troop Welfare

The experience of killing and violence is not the only experience that supplies arousal and richness to the combat experience. Likewise, a feeling of solidarity, camaraderie, and sacrifice may be experienced for one's fellow soldiers. It is possible that the strength of such bonds may be unmatched in civilian life. For Junger, the most unique aspect of the life of a soldier was this close bond of solidarity formed. As a result, a genuine willingness to sacrifice for one another and the displays of affection among soldiers were offered regularly and without deliberation. Articulating the uniqueness of this experience, Junger writes,

> "The willingness to die for another person is a form of love that even religions fail to inspire, and the experience of it changes a person profoundly. What Army sociologists... slowly came to understand was that courage was love" (Junger, 2010, p. 239).

This connection is so strong and intense that it may even be responsible for drawing soldiers back to deployment. Junger writes:

> Perfectly sane, good men have been drawn back to combat over and over again, and anyone interested in the idea of world peace would do well to know what they're looking for. Not killing, necessarily... but the other side of the equation: protecting. The defense of the tribe is an insanely compelling idea, and once you've been exposed to it, there's almost nothing else you'd rather do. (Junger, 2010, p. 214)

In our stoic and heteronormative society, there is simply no match for this otherworldly connection in civilian life. One's civilian co-workers are much more often people who happen to surround you but they are not deeply connected people for whom you would sacrifice your life. There are very few jobs that require a demand of continuous and unanimous sacrifice for the livelihood and well-being of our peers. While we may all long for deeper connections, the difference between civilians and veterans is that civilians have not had the opportunity to truly

experience interpersonal solidarity. Combat veterans know what could be and long for the connection of solidarity once they leave their deployed platoon. Again, this may lead to an intense loss for the soldier, and one that cannot be fully accounted for in the reintegration experience because it is not one that is recognized by society.

METHODS

A series of open-ended and semi-structured interviews were conducted over the course of a one-year period with a former combat Marine in his mid-thirties. The participant had recently completed 14 years of active duty including multiple deployments to Iraq and Afghanistan during the course of both wars. He had received multiple honours for valour and combat exposure during his tenure and had risen to a significant leadership position in his company before retirement. In many ways, his career embodied the standard of ideal for a young Marine enlisting shortly after September 11th. He served as a rifleman, team leader, squad leader, platoon sergeant, and command sergeant. He was able to identify with the lived experience of a young Marine first joining a fire team, as well as holding the duties and responsibilities of a soldier in charge of the life, health, and wellbeing of approximately one hundred and twenty other soldiers.

During the period of time that the interviews were conducted, the participant was holding an intermediary career as a self-employed auto mechanic restoring classical vehicles.[8] Upon immediately leaving the Marine Corps, the participant held several jobs in several fields of work. He also was a full-time student at several points during this time. In his most recent career, he held a prestigious and monetarily successful job in a corporate setting for several years before leaving abruptly. This work was in the field of corporate security and despite struggles and symptoms he was facing after leaving the Marines, his performance at the job was by all accounts a resounding success. Nonetheless, the career was short-lived for a series of reasons laid out in the analysis.

The interviews revealed that, though the participant was living with symptoms associated with PTSD, the etiology of these symptoms were far from the typical conceptualization offered in

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[8]   We say intermediary because he was currently looking for a new and more stable career after leaving one a few years earlier.

a standard diagnosis of PTSD. Instead of being most effected by the violence that he saw and participated in, the individual was most negatively impacted by two aspects of his experience as a soldier. First, James experiences an unshakable feeling of shortcoming and failure regarding what he was unable to accomplish in theatre of war. Second, the solidarity, camaraderie and meaning he experienced in his relationships with members of his platoon were impossible to replicate in his civilian relationships. As a result of several failed attempts at therapy, James spent considerable time re-examining the root of these symptoms in his own life. The lived experience and etiology of these difficulties is accounted for in the results section below.

ANALYSIS

Analysis of the interview protocols followed Giorgi's (2009) descriptive phenomenological method in psychology. The method of phenomenology stems from a school of philosophical thought of the same name. Phenomenologists—which includes notable figures such as Edmund Husserl (1931/2002, 1970), Maurice Merleau-Ponty (1945/1962), and Martin Heidegger (1927/1962)—argue against the reductionism that had become standard practice in the sciences in the early twentieth century. In brief, reductionism is the assumption that any event or experience could be reduced to its simplest parts.

For the study in question, a reductionist might be tempted to call post-traumatic stress disorder an epiphenomenon of the experience of violence as a victim of violence. Such a reduction fails to recognize the complexity of such an experience. To avoid such blanket explanations, phenomenologists must resist the assumption that any event or experience can, in principle, be reduced to a single explanation. This is called avoiding the natural attitude; in phenomenological methodology it is called the phenomenological reduction. Performing a phenomenological reduction, means that you allow the phenomenon to stand for itself, and not some underlying process or cause. For the present study, this means that we will avoid listening to a subject's description and attempting to account for it as merely the victim's unexpected experience of tragedy in war. With the shift in mind-set that is afforded by the phenomenological researcher, analysis may begin.

The descriptive phenomenological method begins, Giorgi explains, "by obtaining concrete descriptions of experiences from others who have lived through situations in which the phenomenon that the researcher is interested have taken place" (p. 96). These descriptions are

the raw data of an empirical phenomenological analysis.

Phenomenological analysis follows three distinct steps: 1) Reading each protocol (that is, the raw data) for a sense of its whole. This means familiarizing oneself with the event as it has been described by each subject. 2) A determination of meaning units within the protocol. In this step of the analysis, the investigator tries to note any affective, experiential, or other shifts that occur within the protocol. 3) Transforming the natural attitude expressions into phenomenologically psychologically sensitive expressions. That is, the *psychological insights regarding the phenomenon* can be discussed without *reducing* the phenomenon to its psychological description.

RESULTS

PTSD & PET – A Misdiagnosis & Insufficient Treatment

This section will provide qualitative analysis after performing extensive interviews with a former combat veteran (James) who was diagnosed with PTSD and underwent PET. The perspective of this former soldier will aid in forming our previous critique of the both the theoretical foundations and effectiveness of PTSD as a diagnosis, as well as and PET as a form of intervention with many combat soldiers.

To begin with, James had misgivings about the way that he was diagnosed. He was diagnosed with PTSD, but felt that the therapeutic environment that he was in was not equipped to understand his experience with violence, or the real etiology of his symptoms:

> "When they try to treat the root problem, they focus on entirely the wrong thing, presuming that exposure to violence is what is causing the symptoms. I can tell you right now that the times that I pulled the trigger with my sights on a person, I have absolutely no issue with those experiences in any way shape, or form. I was accomplishing a mission; I was protecting me and my own and they were an evil person and the world is a better place without them. I really have no issues or qualms (with the violence). The things that bother me the most are the shots that I did not take; not the ones I did."

Again, according to James' experience and contrary to a classical theoretical understanding of exposure to combat violence, he and the majority of soldiers he fought with through multiple tours of combat deployment were *not* averse to the combat, enemy engagement, or the violence of war.

According to James' experience and contrary to a diagnosis of classical PTSD, the majority of soldiers he fought with through multiple tours of combat deployment were not averse to the combat, enemy engagement, or the violence of war. He mentions that he and his former soldiers. He mentions that he and his former soldiers:

> "(We all) *wanted* to do those things. You wanted to put yourself in harm's way. It was never an issue to get volunteers or to get someone to kick in the door of a house where there's guys with AKs in the house. It was always too many volunteers, too many hands up. You wanted to be the one man through the door. A lot of people can't wrap their head around it, how everyone wanted to be that guy. If you ended up getting clipped, that was fine because you were getting clipped instead of one of your guys."

Again, the classical analysis of PTSD would begin from the presumption that soldiers are shocked or averse to the violent circumstances in combat. Repetitive exposure to these fearful and anxiety-provoking experiences is what contributes to the symptoms of PTSD upon returning home. They are what comprise the "stressor" that must be present in order to be diagnosed with PTSD. However, what James reveals here is that though hyperarousal is certainly present, it is *not* due to anxiety or fear, but to combat excitement and the impulse to protect. At the *very* least, we might say that anxiety is *present*, but to reduce the experience to this one emotion certainly misses key aspects of that experience as James explains.

James addresses how many soldiers are diagnosed with PTSD when they did not ever face combat. He discusses the complexity and hypocrisy around this diagnosis:

> "You have so many people seeking treatment and receiving a diagnosis and they didn't even deploy. But they have symptoms of (PTSD) and the doctor will try and find some trauma to attribute to it. Hey – were you ever hazed? Of course they were! Everyone was! But (the doctor) will go back to the hazing and attribute PTSD to that but that is not the root cause. The root cause is just a sense of self-shame and self-guilt. I am not saying that PTSD in the military doesn't exist because of trauma. It does – I still flinch like crazy when a loud noise comes off next to me and that is a symptom of being blown up as many times as I have. But that is not what is causing my substance abuse or causing me to feel like a failure...So many soldiers went and spent 9 months in a country and they got nothing accomplished, which is the vast majority."

Further, when he first described these tendencies to a therapist, James was given a diagnosis on PTSD and he was told that these tendencies were suicidal. James did not feel that he was behaving in a reckless or self-destructive manner, nor did he ever feel that he was

suicidal. He reported frustration that his statement of this did not seem to matter. He was also continually frustrated by his therapist's inability to accept his reality – the fact that he was not averse to the violence of war. Instead, it was what James was ***not*** able to do in war that haunted his conscience upon leaving the theatre of war.

Ultimately, James describes the way that he discovered what was really causing his symptoms associated with PTSD:

> "I did three months of therapy (at a VA sponsored center). The head therapist started doing prolonged exposure stuff with me and I was talking about the most violent, horrific things that I had gone through. The doctor kept saying, 'Why aren't you showing any emotion? "You're not crying. You're not getting choked up. ' I said (to the doctor) because this is not what is screwing me up. That was the light bulb. I realized that this (therapy) is focused on the wrong thing. This entire treatment process is focused on the wrong thing. So if it isn't violence, what is it? Then I started thinking about what really causes me the most internal strife, anxiety, and problems. What causes me to drink? What causes me to seek out crazy behavior or anything else? It wasn't the memories of violence or anything like that. It was a need to prove myself and to accomplish a mission that I never fully could."

In an unintended way, PET was what enabled James to heal. Not because it enabled him to process traumatic and violent episodes from deployment that he had yet to process, but because in its failure – in his therapist's refusal to think that it might be the therapeutic *method* that was wrong, that there must be something wrong with *James* – James was able to realize what was causing him pain. Namely, the military had instilled in him an impossible mission of becoming a war hero and finishing a never-ending war.

Conditioned Ideals & the Inevitable Failure of the Soldier

James offers a keen and unique insight into the social conditioning process that soldiers – in particular, combat MOS soldiers – undergo pertaining to idealism in both training and execution. According to James, the possibility of the perfect execution of a soldier is offered almost ubiquitously to soldiers during training and throughout their careers. Pointed examples of courage, valour, and flawless performance are constantly upheld to soldiers in the midst of enemy engagement:

> "The implosion stems from these overwhelming feelings of guilt and failure from my time overseas. I felt worthless. I felt like a failure and would dwell on, over and over and over,

like a film real in my head. I would project it into the future – if this situation presents itself again, how would I have been able to deal with it differently.… I would have anxiety over (my mistakes) for days and the only way to get rid of that was through more medication, more substance…it was a self-feeding cycle. It all goes back to those feelings of guilt and failure."

Beyond this, the death of one's platoon members and the failure to accomplish a mission can never be chalked up to merely the failure of a specific military task. Ultimately, it was James holding himself up to these impossible tasks, coupled with the loss of camaraderie, solidarity, and meaning that was causing so much pain and trauma.

James articulates what he terms as hero worship in this indoctrination and conditioning process:

"You get into boot camp there is absolute hero worship. You learn to memorize Carlos Hafcock and Dan Dailey and Smedly Butler and the two-time Medal of Honor winners. You memorize that and you worship these people. You are conditioned to worship these people because these people went out and in the process of completing those two things in very extraordinary circumstances and you worship those people. Trying to become those guys is like being a football player and saying you are going to be Tom Brady. It is never going to happen. The chances of you being in that situation where you could prove yourself in that manner are so infinitesimal it is mind blowing. But until you have been pinned with that medal, until you've pulled that shit off, you feel like a failure."

This hero worship in boot camp serves a purpose – it is motivating. Soldiers that hear these stories and hold onto them in combat situations are more likely to act heroically in order to live up to those expectations that are set for them by the military, and that they in turn set for themselves. The problem is that there is no way to meet those expectations, and there is no method for helping veterans cope with that failure, since, again, this is a problem that is not societally (or clinically) recognized.

James goes on to the express the real psychosocial complication that arises from this idealism. He mentions how there is a pervasive level of guilt and shame tied to simply being trained to perform in combat, causing a tendency to embellish war stories which only exacerbates the shame in a vicious cycle:

"When you start talking about the embellishments, like why guys lie, good or bad, nobody wants to admit it but everyone does it. You embellish the story so you can convey some

extreme level of emotion that you felt in that moment and the only way you can ensure somebody else reacts that same way is to make the story so outlandish. That is why so many guys exaggerate about other people's exploits or their own. They say that they were under fire for hours even though it was fifteen minutes because during those fifteen minutes your level of horror and anxiety was so high that the only way that you can ensure that someone who cannot relate to it will relate to it…"

He continues, discussing how idealism became a sickness and turned into a vicious cycle of shame, self-loathing, self-injurious and high-risk behavior. He describes the cycle:

"I got a second OUI and I finally had to say enough was enough. I was looking to get caught. I was searching out that discomfort or pain to justify what I felt inside because I always felt wrong. I always felt like a failure. I always felt screwed up and there is no real reason for it so you create one. You end up creating that strife, that problem, and that struggle… I went in to do a briefing with homeland security. I was hammered drunk during the briefing. I was absolutely shitfaced from the night before. At the end of the briefing I was getting 30 pats on the back, shaking everyone's hand telling me that I did a great job and it was amazing. I am standing there drunk. Mission accomplished. Not only that, but it made the mission even harder. The self-sabotaging mentality that so many guys have, why they pick fights with their family, they are looking for a struggle and they are looking for a fight."

Inevitably, the soldier is left without a war but finds himself still looking for a fight in order to justify the deep shame he feels from his perceived failures in combat.

Mission Completion and Troop Welfare

Related to the issue of ideology and hero worship is the idea of mission completion. We tend to think that missions are simply to-do lists that can be checked off, and that once one returns home from deployment that this means that the mission is definitively *over*. James expressed over and over again that there are two basic principles that are conditioned into the conscience of combat soldiers: mission completion and troop welfare. In every instance of their training, soldiers are reinforced to uphold these principles in every instance and, like hero worship, training emphasizes that these principles can be perfectly obtained in all instances:

"It is the indoctrination that is performed, and a very necessary indoctrination in order to do what you need to do in the context that you are doing it. There are two principles – mission accomplishment and troop welfare. Those are the two biggest things drilled into any service member…When you transition away from (a military setting) – when you get into a civilian setting whether it be family, friends, occupation – you are missing that."

He goes on to mention how after a veteran has left the military and reintegrated into a civilian career, the loss of these two principles contributed to lack a meaning and sense of purposelessness in their lives. James discusses the nuances of this transition:

In a lot of cases it is great to hire from the military because you see that drive. There is a mission and we go complete it. That is why I was successful, at least initially, coming out and getting into corporate America and doing very well until I basically imploded. That transition is difficult for a lot of guys. They lack a sense of purpose. That is why you see so many wandering around, or their mission becomes their existing condition.

As we find in this passage, the drive to complete a mission that has been indoctrinated in James is, at least initially, a real boon to his employers. His employers trust him, are in awe of his work ethic, and reinforce this tendency with promotion and praise. However, the mission completion drive in a military career is never fully replicated in a civilian career. In short, there just isn't enough at risk to satisfy the drive. For James - and as he alludes to, perhaps many former combat soldiers – the vacuum existing around the drive for mission completion is at best disorienting and at worst traumatizing. As he says, the soldier without a mission is stripped of purpose; there is no one to save, defend, kill, or protect. There becomes a tendency to transfer the drive to mission completion onto one's very existence and, as we will see, toward self-injurious behaviours.

As eluded to previously, for several years post-deployment, James had a corporate career in security. He talked about the way that he brought these ideas of mission accomplishment and troop welfare into his civilian career in ways that were largely successful. The commitment to these ideas eventually became problematic, however. In one of the most striking stories that James told us, he talks about responding to a crisis at work the way he would have during deployment:

"We got a call one day that there was a guy with a gun in the parking lot. Nobody at (job) was armed. I told them to call 911 and I start running out the door. Everyone was wondering what I was going to do. I told them I was going to run him over with my truck. I got in my truck and screamed down the street 125 miles per hour, came into the parking lot sideways and was going to hit the guy with my truck. I was just going to run him over. If he started shooting at me I was just going to duck behind the dash. That was my mentality at the time. It ended up being a federal marshal who had pulled over a drunk

lady on the street...I didn't think anything of that but they thought I was insane for being willing to do that."

There are two senses in which missions are not over. First, the wars in Iraq and Afghanistan did not have clear-cut goals or timelines. Since the war is not against a country but an ideal, it is impossible to ever be finished. One can't come home and say, "Well, I'm done fighting the war on terror! Mission accomplished!"

Further, since James was having trouble reintegrating, as so many veterans do, the experience remained alive for him. In many ways, James hadn't come home yet at all:

> "Every time I would walk up a staircase, I am checking corners like I had a rifle, squaring off corners and buildings and I wouldn't even realize I was doing it. You get into this mode where you don't have a mission and you don't have troop welfare. You are failing yourself because you are self-destructive. I was failing my wife, failing my friends because I was missing dates. It is a self-feeding cycle, especially when substance abuse gets thrown in. From the outside looking in, everyone thinks, "Oh, Clay drank too much last night." But to me, it's an abject failure of both mission accomplishment and troop welfare. "

Years after he had come home, James was still fighting, and still failing. Mission accomplishment and troop warfare had remained his targets and since these aspects of his integration were being missed in therapy because therapy was focused only on the traumatic experience of violence, James was lost.

Finally, Mission accomplishment tendencies also lead to a desire to seek out high-adrenaline and high-risk behaviours. Similar to a troop movement into enemy territory, these behaviours are challenging and bring a level of risk that provides a rush:

> "We went out to dinner one night and I wasn't the DD, but the DD ended up drinking so I ended up driving. No big deal – I've got a mission. I am going to take care of these guys. I am going to get these guys home. That is my mission and it doesn't matter if I have had a few drinks. After that, I was in three really bad snow mobile crashes and I just kept doing it. Breaking bones. I really don't know how many bones I have broken and I am not talking about deployment. I am talking about doing other behaviours, searching out for that adrenaline rush, pain, and mission. And it is the same thing across the board with so many other veterans. Once, I was out on a sled and I high sided it at 90 miles per hour and went into the trees. I actually split my helmet in half. I tore SI joints, my hips, broke a bunch of ribs, really mangled my face and I was riding again the next weekend. I mean, it was insane."

James goes even further, explaining that there is indeed a fine line between what look like suicidal tendencies and what are actually sacrificial tendencies in the honor of upholding troop welfare. Following on the story of his turret gunner who was shot when he – James - was exposing himself intentionally to fire, he discusses what actually plagued him from the experience:

> "Why did the enemy shoot him and not me? That is what screwed me up from that event. Not holding my homeboy's skull together. I am not bragging about what I was willing to do. What I am talking about is the internal strife in relation to that situation…The first person I told about that story told me I was suicidal, which was not the case at all. If I am dead, how do I protect my guys? Is there a chance I am going to die? Yes. But I've got all of my armor on. I volunteered to kick every door in. It's not because I was a badass, because I and everyone else were scared shitless. I just didn't want to see anyone else hurt. It's not because you are brave or because you are suicidal; it's because you fear seeing someone else get hurt. That fear drives you to be willing to do things that you normally would not."

What James describes here ties back to Junger's analysis of what the soldiers in the Korengal Valley experienced when they found themselves attracted to war. As Junger writes, it was not the killing of the enemy that was alluring to the young men as much as it was the protection of their comrades. The feeling of taking responsibility for the protection of the lives of one's peers was and is a deeply compelling emotional lure. James was attracted to this experience both in combat and back at home in his civilian life. Unfortunately, symptoms and psychosocial struggles began to arise not purely as a result of this drive, but out of the fact that there was no longer a proper context with which to activate these desires. In Iraq, James was a hero who protected his tribe; in America, he was a mission-less mercenary fighting a war against no enemy and with no innocents to protect.

The Useful Alien

One of the more intriguing and, yet, socially disturbing aspects of James' reintegration into a civilian career was how he was viewed by his employer, managers, and coworkers. Put simply, James' superiors and co-workers simply did not know what to do with him. In some ways, they found his commitment to troop welfare and mission accomplishment an incredibly potent and effective tool for getting difficult tasks done, holding his subordinates accountable,

and producing solid outcomes in the complex world of corporate security. On the other hand, James' behavior and social tendencies were confounding, bizarre, and even disturbing. For the years he was working in corporate security, for the most part, his superiors and peers allowed for these tendencies to continue in order to reap the benefits of James' effectiveness on the job. Ultimately, the continued decisions to allow James to behave in antisocial and self-destructive ways in order to use his tendencies for effectiveness in his job led to an enabling of James' worst instincts and caused an exacerbation of his symptoms, two separate arrests, and a profound feeling of social isolation in the world the very country he fought to defend for 15 years.

Reflecting back on the brief he gave to the FBI and homeland security while heavily inebriated, James expresses why his managers and superiors were willing to tolerate such high-risk, antisocial, and potentially self-injurious behavior:

> "I had a serious drinking problem at that point. I was in a unique situation. The problem was that my problems kept getting worse and worse and worse because it was the exact same mind-set...They were willing to look it over because of the results that I was giving them. (When I took over the job) it went from them turning over the position every nine months into (my turning it into) a global security program from step one. It was a very positive time for everyone involved. Everyone was making more money from the bottom up. Everyone was happier. The turnover of employees was cut in half...They were just willing to ignore it...But I was H.R.s worst nightmare."

James was a ticking time bomb socially. He had no respect for his peers and was slowly edging closer to self-injurious tendencies in the workplace. In his estimation, he was a soldier and, thus, he was never uncomfortable with the discomfort in his life even if he himself was the source of that discomfort. Moreover, James was effective in the workplace and, though misunderstood by his managers and intimidating to his peers, he could put people in place, hold his peers to severe expectations, drive a hard sleigh, and complete an onerous mission. He went on to describe how, on a day-to-day basis, he was stark and borderline abusive to his subordinates in order to push them to accomplish the mission. He describes an encounter with one of his subordinates where the worker had a heart attack while he was in a meeting being scolded by James. Human resources stepped in and looked to terminate but his bosses and managers always inevitably protected James and even, in this case, laughed off his behavior. Ultimately, he was an effective hard-ass; a soldier who was willing to get his hands dirty, communicate what no one had the gall to say, and confront problems in the workplace head-on.

James continues, describing why, in his purview, he was allowed to behave in such an antisocial way toward his peers and subordinates. Beyond the effectiveness of his style, James mentions how his managers, peers, and subordinates were simply afraid of him. He mentions how he had openness to conflict that was deeply unsettling and intimidating to his peers and managers:

> "Nobody wanted conflict with me; nobody wanted to confront me. My attitude, mentality, personality, whatever you want to call it...when it came down to the push and shove of things, one of the better things that you get with the former military is that conflict does not bother me in any way, shape, or form. I am more comfortable when dealing with conflict than I am with smooth sailing. So for somebody to try and confront me with issues or problems or anything on a personal level, I don't think anybody wanted to do it."

Returning again to a recurrent motif in the analysis, life for James was understood as a series of conflicts - complicated, difficult, and messy missions that he was charged with accomplishing. These missions could easily be perceived as discomforting to the faint of heart, but James was energized and excited by the idea of conflict resolution. If there was a perceived limit to a specific task, James was going to find the boundary walls and tear them down. In short, this is incessant idealism turned into a boundary-pushing process was discomforting and demanded that all individuals involved come to a new baseline level of comfort with suffering and struggle. James found quickly that his peers and subordinates feared him and simply complied with his style as a way of avoiding him. His bosses – perhaps intimidated by him as well – were just pleased that the bottom line was being met in ways they had not heretofore imagined.

CONCLUSION AND FURTHER DISCUSSION

James case study demonstrates in vivid nuance that we need to be open-minded and aware that there are many different ways for a soldier to experience the combat setting. Though we do not contend that his story show us that PET is a failure as a method to treat PTSD, quite clearly a more nuanced conceptualization of the combat experience is imperative. This study reveals that what is disturbing and traumatic about combat is not always the experience of violence. James exposes the dangerous idea that the struggle soldiers face upon reintegrating into a civilian life may have little to do with the anxiety produced from trauma, but the idealism and guilt complexes built into the psyche of the soldier incessantly longing for a more perfect form of

execution. As we continue to resist this temptation, we will continue to perpetuate a limited narrative and concept around these struggles. However, if we want to help veterans who are reintegrating into civilian society, we must open our minds to a larger conceptualization of these struggles.

Though it is more convenient, and would certainly benefit everyone if there were a single treatment that worked for everyone, that is simply unrealistic. Operating from a singular theoretical understanding of combat is detrimental, as is operating from a singular treatment perspective. This has been problematic and dangerous in the past, and it continues to be problematic and dangerous in the present. The phenomenological perspective reminds us that we must return to the lived experience of the individual in order to successfully treat them. Until we do this on a wider scale, reintegration will remain an urgent problem.

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