

“WOTS” NEXT - THE WAR ON TERROR SYNDROME:
Stress, Traumatic Brain Injury, and Limited Resources Combine to
Make Veteran Reintegration More Challenging than Ever

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Abstract

As the Global War on Terror (or “struggle against violent extremism”) continues, many veterans are returning home from the front lines with, not only physical, but psychological injuries that may take a lifetime to recover from. This paper discusses the increasing numbers of veterans who survive such serious injuries on the front lines, but must now deal with the lifelong physical and emotional scars. Has our society learned the harsh lessons of the Vietnam and Gulf Wars how to successfully reintegrate these veterans?

“WOTS” NEXT - THE WAR ON TERROR SYNDROME

Nivine Zakhari

I. INTRODUCTION

The War on Terror may very well be in its last throes¹ as this nation is now engaged in a seemingly endless “struggle against violent extremism.”² For our nation’s troops, the transition back from combat zone to hearth and home seems not to happen quick enough. But even for those fortunate enough to avoid physical injuries sustained in combat, the return from such an ordeal can introduce another host of behavioral and psychological problems as these forever changed men and women try to reintegrate back into their families and communities.

While Acute and Post-traumatic Stress Disorders (PTSD) are not new concerns for military health care professionals,³ the increasing number of survivable traumatic brain injuries (TBIs) sustained in combat introduces new challenges to veteran reintegration at a level not experienced in prior conflicts.⁴

II. BACKGROUND

As a preface to the discussion regarding special needs for veterans returning from Iraqi operations, in this section I will provide some background on the typical stress disorders encountered by veterans (with or without accompanying physical trauma), other behavioral and psychological concerns prevalent in military populations, and some of the behavioral and psychological impairments that result from traumatic brain injuries.⁵

A. *Stress Disorders*

Within the realm of stress disorders, two distinct categorizations occur depending on the temporal relationship between the stressors and symptoms, immediate or delayed.⁶ Whether or not the stressors produce unreasonable anxiety or other abnormal psychiatric response requires evaluation of many contributing factors, including the individual’s personality traits, coping skills, and available social support.⁷

1. Acute Stress Disorder

During or immediately after a traumatic or extremely stressful activity, individuals may experience “strong emotions, disbelief, numbness, fear, and confusion accompanied symptoms of autonomic arousal and anxiety.”⁸ Any pre-existing sub-clinical personality disorders, depression, anxiety, or underlying Post-Traumatic Stress Disorder⁹ may further be aggravated by such exposure.¹⁰ This “battle fatigue” or “combat stress” is not to be unexpected, however, proper evaluation and accommodations for those suspected of maladaptive traits may be required to maximize their effectiveness in continuing high-stress duties.¹¹

Once front-line medical personnel or commanding officers have determined the need to evacuate personnel, evaluations are made by members of Combat Stress Control (CSC), including resources from the Division Mental Health Section (DMHS).¹² As the furthest forward resources involved in providing health care, this second echelon¹³ of caregivers must make the determination whether any acute symptoms require further treatment at Combat Support Hospitals (CSHs) in the Corps Support Area.¹⁴

At the third echelon of care, in CSHs, more medications are readily available to treat acute symptoms of traumatic stress.¹⁵ Over ninety percent of the patients that reach this level of psychiatric care in Iraq and Kuwait are still able to return to duty (RTD).¹⁶ Remaining patients that are not expected to RTD within a week are then evacuated to Germany or Spain.¹⁷ At this fourth echelon of care, a determination is made whether patients may still be utilized away from the front lines, since a return to combat duty at this point is unlikely.¹⁸

2. Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) includes autonomic arousal, intrusive thoughts, apathy, and social withdrawal occurring several days to more than a week following the traumatic event.¹⁹ PTSD symptoms are considered chronic if they persist for several months or years beyond the original stressor.²⁰ Unlike ASD, PTSD symptoms may continue to interfere with the patient's functioning for some time after removing aggravating stressors.²¹ They may also interfere with effective treatment, particularly where a patient exhibits pronounced dissociation or avoidance behaviors.²²

B. Other Concerns Unique to Military Personnel

During deployment, mental health services may be obtained either by individual (self) or command-referral.²³ Unfortunately, there is still much stigma associated with mental illness within the military, so self-referrals are rarely used.²⁴ In fact, persistent attempts to self-refer are more often associated with malingering than bona fide mental health concerns.²⁵ Extreme attempts to feign unfitness for military duty still make the news around the world.²⁶

Pre-deployment concerns regarding the preparedness of National Guard, Army and Marine reservists for extended combat operations are also of concern.²⁷ With plans for troops to remain in the area at least another four years, the administration is cutting back Guard and Reserve participation to 25%, replacing them with newly expanded active-duty resources.²⁸ Army leaders refuse to admit the record number of casualties sustained in August 2005 is related to any deficiencies in the former's preparedness.²⁹ However, clinicians are advised of the additional burdens placed on Guard and Reserve members versus their active-duty counterparts due to the disruption of their civilian lives during deployment.³⁰ For those service members, "deployment may result in loss of civilian employment, financial penalty, or separation from family who may be left far from any military base or resources... [and] assign[ments] to units in which they know no personnel, leading to added stress and preoccupation."³¹

C. Traumatic Brain Injuries

What may become the "signature wound" of the Iraq war is Traumatic Brain Injury (TBI).³² Although some consider TBI "among the most serious public health problems facing the United States and the rest of the developed world,"³³ only recently has there been so much attention focused on military personnel returning from Iraq and Afghanistan with TBI.³⁴ Frankly, in prior conflicts, many soldiers with TBI would not have survived long enough for their long-term care needs to be a consideration.³⁵ Today, the special needs of veterans with TBI is of growing concern, along with that of the general population subject to accidents, falls, and gunshot wounds causing significant, yet now survivable, brain damage.³⁶

While the acute and post-traumatic stress disorders previously discussed³⁷ may leave temporary to lasting changes on a veteran's personality,³⁸ TBI may also leave such psychological

and emotional scars through physical trauma to brain segments controlling behavioral and emotional responses.³⁹ The line between purely psychiatric and neurological injuries is difficult to draw at times since even the most advanced scientific procedures can only infer the thoughts, motivations, and mental processes occurring in any individual patient's brain.⁴⁰ As Professor William J. Winslade notes recently, "[m]any with severe brain injuries lack the ability to control their thoughts, emotions, impulses and their conduct. They may become uninhibited, promiscuous, anxious, paranoid or violent."⁴¹ Patients with clinical anxiety, stress, mood or personality disorders⁴² may exhibit similar symptoms and behavior with few, if any, identifiable physical causes.⁴³ Recent research by NIMH suggests that the hippocampus may be responsible for some veterans developing intrusive memories and flashbacks typical of PTSD.⁴⁴ Much has also been written to assist courts and juries in distinguishing the root cause of personality changes following TBI.⁴⁵

III. DISCUSSION

While the United States is still reminded of the disastrous impact of negative treatment of returning soldiers from an unpopular war,⁴⁶ the general public and civilian clinicians need to be aware of the significant burdens many returning veterans face as a result of their psychological and/or physical wounds in combat areas. While public dissatisfaction with the current "war" is (and should be) directed at administration officials and not the troops themselves,⁴⁷ the prospects of domestic terrorist attacks,⁴⁸ possible reinstatement of the draft,⁴⁹ government resource constraints,⁵⁰ and limited civilian experience with combat veterans⁵¹ may make this one of the most difficult homecomings military personnel have had to endure.

A. *WOTS different from Vietnam and the Gulf War?*

Although Vietnam and Gulf War veterans are recognized as candidates for service-connected health care benefits even years after completing their tours of duty,⁵² current conditions in the United States make reintegration of our most recent class of combat veterans even more challenging.

1. Domestic terrorist attacks are a real threat

Clinicians recognize that, even for civilians who have never been in a war zone, anxiety may become a problem with the implementation of High Risk Terrorist Alerts.⁵³ For many civilians located in New York City, the events of September 11, 2001 are an unforgettable part of their psyches.⁵⁴ Recent attacks on allies' homeland, including Madrid, Spain⁵⁵ and London,⁵⁶ further aggravate any underlying inability to manage the accompanying stress or anxiety.⁵⁷ These difficulties are exacerbated for military personnel returning from combat areas.⁵⁸ Some report frustration at seeing civilians carrying on with their lives instead of showing greater vigilance for potential domestic threats.⁵⁹

During June and July of 2002, five Ft. Bragg soldiers were involved in separate murders, which Army investigators later blamed on stress.⁶⁰ Four of the soldiers murdered their wives, two of whom also committed suicide.⁶¹ A fifth incident involved a civilian woman who killed her husband, a Special Forces Major.⁶² Although the couples involved in each case had histories of marital problems,⁶³ the surprising outbreak of violence highlighted the need for psychological screening of troops returning home.⁶⁴

2. Active-duty Resources are Stretched Thin

As previously mentioned,⁶⁵ the heavy reliance on Guard and Reserve members in Iraq highlights the resource constraints in today's armed services.⁶⁶ Although more active-duty members are now being assigned to Iraq, quality of life issues, growing pessimism about the U.S. role in Iraq, and continuing instability in the region require increasing compensation figures to attract the most qualified personnel.⁶⁷

3. Limitations of Government Support

Some veterans claim they learn little, if anything, about the support services available through the Department of Veteran Affairs (VA) and affiliated Vet Centers after completing their tours.⁶⁸ As a response to the prevalence of PTSD among Vietnam veterans, Congress created the National Center for PTSD within the VA in 1989.⁶⁹ Since then, the NCPTSD has become a clearinghouse for PTSD related information not only for military personnel, but for civilian victims of traumatic events including child abuse, rape, assault, natural disasters, and terrorist attacks.⁷⁰ VA Medical centers and Vet Centers provide mental health services for veterans either as part of their health insurance coverage or based on the veteran's ability to pay.⁷¹

With a budget of over \$70 billion, the VA provides a number of services beyond healthcare, including mortgage, higher education, and job training assistance.⁷² However, the number of employees handling disability claims have dropped since the Gulf War even though the number of claims to process have increased.⁷³

Statistics show veterans appeal approximately 15 percent of their denied claims, where up to 60% are then approved.⁷⁴ Some speculate that this high rate of reversals shows an even higher rate of unsupportable denials by claims evaluators, where the remaining veterans are either unwilling or unable to fight for appeal.⁷⁵ Given these circumstances, today's soldiers in combat should be prepared to have documentation ready for any service-connected injuries, physical or psychological, to be treated in the future.

4. Limited experience of civilian clinicians with recent combat veterans

As a society, the coverage of the first Gulf War and now the War on Terror, provides persistent cable news fodder accessible 24 hours a day. While the coverage reaches many, the reality of working with combat veterans as they reintegrate back into society is not necessarily something many civilian clinicians have recent experience with.⁷⁶ Although military support groups are aware of the issues in treating combat veterans, for the general public and uninitiated health care providers, the unique concerns of military patients must be grasped to properly deal with the long-term effects of their service.⁷⁷

B. Preparing for the future

While some may claim pre-deployment preparations need to be shortened, not lengthened,⁷⁸ for many of the Guard and Reserve members called to duty for the War on Terror, it would be a worthwhile investment to learn about the numerous government services available after deployment. Veterans and their family members should familiarize themselves with the claims process to ensure appropriate benefits are received after completing service.

Civilian clinicians can also take advantage of many of the resources provided by the VA through its NCPTSD to ensure proper considerations are made for the unique circumstances military personnel must contend with.

IV. CONCLUSION

While there are many obvious differences between today's War on Terror and previous conflicts in Vietnam and the Gulf War, our combat veterans still need just as much psychological and emotional support from their families and communities as they need financial support to complete their missions and return home safely. With the possibility of remaining engaged in hostile areas for more years to come, greater sensitivity to the needs of combat veterans after serving may provide the reassurance our volunteer soldiers need to continue to protect the interests of the United States abroad while fostering freedom and democracy in other critical areas of the world.

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¹ See *Iraq insurgency in 'last throes,' Cheney says*, CNN.com, May 31, 2005, at <http://www.cnn.com/2005/US/05/30/cheney.iraq/> (posted June 20, 2005).

² See Eric Schmitt and Thom Shanker, *Washington recasts terror war as 'struggle'*, INT'L HERALD TRIBUNE, July 27, 2005, at <http://www.ihf.com/articles/2005/07/26/news/terror.php>.

³ See U.S. DEPARTMENT OF VETERAN AFFAIRS, NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER (NCPTSD), THE IRAQ WAR CLINICIAN GUIDE 1, (Paula P. Schnurr & COL Stephen J. Cozza eds., 2d ed. 2004), available at <http://www.ncptsd.va.gov/war/guide/IraqGuide.pdf>. See also discussion, *infra* Part II.A.

⁴ See Gregg Zoroya, *Key Iraq wound: Brain trauma*, USA TODAY, Mar. 3, 2005 (reporting on Army doctors who believe TBI "may come to characterize [the Iraq] war, much the way illnesses from Agent Orange typified the Vietnam War"), available at http://www.usatoday.com/news/nation/2005-03-03-brain-trauma-lede_x.htm.

⁵ See generally WILLIAM J. WINSLADE, CONFRONTING TRAUMATIC BRAIN INJURY: DEVASTATION, HOPE, AND HEALING (1998).

⁶ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 11-13.

⁷ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 11.

⁸ IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 11.

⁹ See discussion, *infra* Part II.A.2.

¹⁰ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 11.

¹¹ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 11.

¹² See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 9 (noting these resources typically include a Psychiatrist, Psychologist, Social Worker and enlisted Behavioral Science Specialists).

¹³ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 9-10 (describing the five echelons of care in military medical evacuation and service delivery). The first echelon includes front-line medical personnel who typically deal with stabilizing physical battle injuries prior to evacuation. See *Id.*

¹⁴ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 9-10.

¹⁵ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 10 (noting the third echelon is the first level of care where a fully staffed pharmacy is available).

¹⁶ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 10.

¹⁷ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 10 (noting that “Iraq veterans... evacuated to Landstuhl Regional Medical Center in Germany or US Naval Hospital, Rota Spain are rarely returned to duty.”).

¹⁸ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 10.

¹⁹ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 11-13.

²⁰ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 12.

²¹ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 12-13.

²² See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 13.

²³ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 16.

²⁴ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 16.

²⁵ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 16-17. Corporal Max Klinger, in the popular TV show M*A*S*H, was a fictional portrayal of the chronic malingerer, self-referring for mental health services to avoid undesirable duty. See Wikipedia, Maxwell Klinger (describing the character as “[m]aking no secret of his disdain for the Army, Klinger constantly tried to get a discharge, [but] was unwilling to accept a dishonorable discharge and instead tried to convince his commanding officer to grant him a medical discharge on the basis of mental instability”), at http://en.wikipedia.org/wiki/Maxwell_Q._Klinger.

²⁶ See *Doctor Fakes Insanity to Avoid Military*, Feb. 3, 2005 (reporting “[a] Norwegian doctor called in for military service would have made the malingerer Cpl. Klinger of “M A S H” proud.”), at <http://www.phillyburbs.com/pb-dyn/news/84-02032005-443647.html>.

²⁷ See Robert Burns, *Army Planning for 4 More Years in Iraq*, Yahoo! News, Aug. 20, 2005 (reporting “some in the reserve forces have indicated to Army leaders that they think they are spending too much time in pre-deployment training, not too little”), at http://news.yahoo.com/s/ap/20050821/ap_on_go_ca_st_pe/army_chief_interview (last visited Aug. 21, 2005).

²⁸ See Burns, *supra* note 27.

²⁹ See Burns, *supra* note 27 (reporting a record 42 fatalities for Guard and Reservists during August 2006, but Gen. Peter Schoomaker “disputed the suggestion by some that the Guard and Reserve units are not fully prepared for the hostile environment of Iraq”).

³⁰ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 7.

³¹ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 7.

³² See Zoroya, *supra* note 4.

³³ WINSLADE, *supra* note 5, at xiii (*Preface*).

³⁴ See Zoroya, *supra* note 4.

³⁵ See Zoroya, *supra* note 4 (noting 437 cases of TBI diagnosed at Walter Reed Army Medical Center from January 2003 to January 2005 and another 97 Marines and sailors with temporary or permanent brain damage at National Naval Medical Center in Bethesda, MD, between August 2004 and February 2005).

³⁶ See Zoroya, *supra* note 4 (reporting Army doctors “screened every arriving servicemember wounded in an explosion, along with those hurt in Iraq or Afghanistan in a vehicle accident or fall, or by a gunshot wound to the face, neck or head”).

³⁷ See discussion, *supra* Part II.A.

³⁸ See NIMH, *Facts about Post-Traumatic Stress Disorder* (2002), at <http://www.nimh.nih.gov/publicat/ptsdfacts.cfm> (discussing manifestations of psychological trauma, including psychosomatic symptoms) (posted Apr. 9, 2004).

³⁹ See WINSLADE, *supra* note 5, at 89-105 (discussing “How Families Become Victims” dealing with the behavioral, emotional, and personality problems affecting many TBI patients). See also IRAQ CLINICIAN GUIDE, *supra* note 3, at 34-36 (applying lessons learned from Vietnam veterans with chronic PTSD to help prevent family breakdown).

⁴⁰ See generally National Institute of Neurological Disorders and Stroke (NINDS), Neurological Diagnostic Tests and Procedures, at http://www.ninds.nih.gov/disorders/misc/diagnostic_tests.htm (reviewing all the modern diagnostic tests currently available to diagnose neurological diseases and injuries).

⁴¹ William J. Winslade, *The Legal Column: Traumatic Brain Injury and Criminal Responsibility*, 10 No. 3 LAHEY CLINIC MEDICAL ETHICS 4 (2003), available at http://www.lahey.org/NewsPubs/Publications/Ethics/JournalFall2003/Journal_Fall2003_Legal.asp.

⁴² See generally National Institute of Mental Health (NIMH), Health Information, at <http://www.nimh.nih.gov/healthinformation> (providing public information on the signs, symptoms, diagnosis and treatment of several mental health concerns including depressive, anxiety, panic, and post-traumatic stress disorders).

⁴³ See American Psychiatric Association, *Let's Talk About Facts: What is Mental Illness?* (advising the general public that “[t]he exact causes of mental disorders are unknown, but an explosive growth of research has brought us closer to the answers. We can say that certain inherited dispositions interact with triggering environmental factors.”), available at <http://www.healthyminds.org/multimedia/whatismentalillness.pdf> (last visited Aug. 21, 2005).

⁴⁴ See NIMH, *Facts about PTSD*, *supra* note 38.

⁴⁵ See generally Jerry Von Talge, *Personality Change Due to Closed Head Trauma*, 34 AM. JURIS. PROOF OF FACTS 3d 1 (2005) (reviewing the legal considerations and elements of proof generally necessary to support a finding of personality change due to closed head trauma); ROBERT H. BLANK, *BRAIN POLICY: HOW THE NEW NEUROSCIENCE WILL CHANGE OUR LIVES AND OUR POLITICS* 80-104 (1999) (discussing environmental and biological factors affecting the brain and individual behavior).

⁴⁶ See R.W. Apple, Jr., *Confrontation in the Gulf; Views on the Gulf: Lawmakers Versed in Vietnam*, N.Y. TIMES, Sep. 16, 1990 (reporting during the first Gulf War U.S. Representative John Murtha's concerns that "[t]he aura of Vietnam hangs over these kids... Their parents were in it. They've seen all these movies. They worry, they wonder."), available at 1990 WLNR 2943429. See also Michael J. Davidson, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415 (1988) (discussing the "disproportionately high rate of psychological problems and criminal encounters" Vietnam veterans face and their resulting use of PTSD as a criminal defense).

⁴⁷ See Schmitt & Shanker, *supra* note 2 (noting "[n]ew opinion polls show that the American public is increasingly pessimistic about the mission in Iraq"). See also Davidson, *supra* note 46, at 416-17 (discussing the unique features of the Vietnam war that increased the likelihood of veterans experiencing psychological problems yet reluctance in seeking government assistance)

⁴⁸ See discussion, *infra* Part III.A.1.

⁴⁹ See discussion, *infra* Part III.A.2.

⁵⁰ See discussion, *infra* Part III.A.3.

⁵¹ See discussion, *infra* Part III.A.4.

⁵² See Holding, *infra* note 68 (quoting James O'Reilly, a Vietnam veteran and professor at the University of Cincinnati College of Law, "[The VA] is getting the aging baby boomers with the psychological baggage of having been involved in Vietnam. It's getting the 80- year-old World War II vets who are now indigent, and it's getting very angry young people back from Iraq and saying, 'Where's mine?'").

⁵³ See American Psychiatric Association, *Coping with Anxiety During High Risk Terrorist Alerts*, at <http://www.healthyminds.org/highriskterroralerts.cfm> (last visited Aug. 21, 2005).

⁵⁴ See Sandro Galea, et al., *Psychological Sequelae of the September 11 Terrorist Attacks in New York City*, 346 NEW ENG. J. MED. 982 (Mar. 28, 2002) (a study of PTSD and depression among residents near ground zero, within 2 months of the attack); Schlenger, W.E., et al., *Psychological reactions to terrorist attacks, Findings from the National Study of Americans' Reactions to September 11*, 288 No. 5 JAMA 581 (Aug. 7, 2002) (finding New York City residents exhibited more PTSD symptoms than Washington, D.C. residents and the rest of the country), available at <http://jama.ama-assn.org/cgi/reprint/288/5/581>.

⁵⁵ See *Bin Laden fatwa as Spain remembers*, CNN.com International, Mar. 11, 2005 (reporting on Muslim clerics declaring an Islamic edict against Osama bin Laden on the anniversary of the Madrid bombings that killed 191 people in 2004), at <http://edition.cnn.com/2005/WORLD/europe/03/11/madrid.anniversary>.

⁵⁶ See BBC News UK Edition, *In Depth: London Attacks* (including tributes to the 52 victims of the July 7, 2005 London bombings), at http://news.bbc.co.uk/1/hi/in_depth/uk/2005/london_explosions/.

⁵⁷ See APA, *Coping with Anxiety*, *supra* note 53.

⁵⁸ See Candace Monson, *How Terrorist Acts May Affect Veterans*, A National Center for PTSD Fact Sheet (discussing the increased sensitivity veterans may have to traumatic events, such as terrorist attacks), at http://www.ncptsd.va.gov/facts/disasters/fs_veterans_disaster.html (last visited Aug. 21, 2005). See also Schlenger et al., *supra* note 54 (noting that “[b]ecause U.S. military deployment to Afghanistan was imminent at the time of the survey, the study also examined the relationship of military service to PTSD and general psychological distress.”)

⁵⁹ See Bob Sminklemeyer, *Taking the Dog Tags Off*, in *In Iraq for 365* (Jan. 28, 2005) (a blog by an Army journalist formerly stationed in Mosul, Iraq discussing, among other things, the trouble he has had with reintegration), at <http://desert-smink.blogspot.com/2005/01/taking-dog-tags-off.html> (last visited Aug. 21, 2005).

⁶⁰ See *Ft. Bragg Killings Blamed on Stress*, CBSNews.com, Nov. 7, 2002 (reporting the findings of Army investigators on the apparent rash of murders and suicides involving troops recently returned from Afghanistan), at <http://www.cbsnews.com/stories/2002/07/26/national/printable516500.shtml> (last visited Aug. 14, 2005).

⁶¹ See *Ft. Bragg Killings Blamed on Stress*, *supra* note 60.

⁶² See *Ft. Bragg Killings Blamed on Stress*, *supra* note 60.

⁶³ See *Ft. Bragg Killings Blamed on Stress*, *supra* note 60.

⁶⁴ See *Ft. Bragg Killings Blamed on Stress*, *supra* note 60 (noting “Commanders will be ordered to watch out for symptoms of depression and anxiety among their troops. Officials also are developing an intervention policy to protect spouses from domestic violence.”).

⁶⁵ See discussion, *supra* Part II.B.

⁶⁶ See Lawrence J. Korb, *All-volunteer Army shows signs of wear*, ATLANTA J. CONST., Feb. 27, 2005 (reporting that the National Guard and Reserves are missing their recruiting goals at the beginning of fiscal year 2005), available at http://www.ajc.com/hp/content/auto/epaper/editions/today/issue_2412c833e1fb81ff0085.html.

⁶⁷ See Korb, *supra* note 66 (noting recruiting goals continue to be missed even with “[b]onuses for special operations personnel willing to re-enlist [of] \$150,000”).

⁶⁸ See Reynolds Holding, *Insult to Injury*, 2005 LEGAL AFF. 26, 26-27 (2005) (reporting that, of the 210,000 veterans deployed to Iraq and Afghanistan since the start of the War on Terror, almost 40,000 filed for disability benefits. Some veterans claim they were not informed of the availability of such benefits from military personnel.).

⁶⁹ See Department of Veterans Affairs, *About the National Center for Post-Traumatic Stress Disorder*, at <http://www.ncptsd.va.gov/about/history/index.html> (last visited Aug. 21, 2005).

⁷⁰ See *About the NCPTSD*, *supra* note 69.

⁷¹ See Department of Veterans Affairs, *Seeking Help for Posttraumatic Stress Disorder*, at http://www.ncptsd.va.gov/facts/treatment/fs_seeking_help.html (last visited Aug. 21, 2005).

⁷² See Holding, *supra* note 68, at 27.

⁷³ See Holding, *supra* note 68, at 29 (noting “[f]rom 1992 to 2001, the number of full-time employees handling benefits requests dropped from almost 15,000 to under 11,000. Meanwhile, the number of unresolved claims rose from about 530,000 to almost 670,000.”)

⁷⁴ See Holding, *supra* note 68, at 30.

⁷⁵ See Holding, *supra* note 68, at 30.

⁷⁶ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 1 (acknowledging “some clinicians... may not have an understanding of the experiences of the military patient, the military system in which he or she serves, the military medical services available, or the potential impact of medical decisions on the service member's future military career.”).

⁷⁷ See IRAQ WAR CLINICIAN GUIDE, *supra* note 3, at 1.

⁷⁸ See Burns, *supra* note 27.