Warring Identities: Identity Conflict and the Mental Distress of American Veterans of the Wars in Iraq and Afghanistan

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Abstract

Drawing from 26 life story interviews of recent American veterans, this paper analyzes the identity struggle faced by soldiers returning from Operation Iraqi Freedom and Operation Enduring Freedom and reentering the civilian world. Instead of examining veterans' problems as a consequence of post-combat mental illnesses such as PTSD and major depression, we analyze the contrast between the participants' identities as soldiers and their identities as civilians. We find that the postwar transition causes adverse mental health effects that stem from contrasts between the military's demands for deindividuation, obedience, chain-of-command, and dissociation and the civilian identity expectations of autonomy, self-advocacy, and being relational. Veterans' reintegration to civilian society is further hindered by a culture that is perceived (by veterans) as having decreased understanding of the soldier/veteran experience itself. These identity conflicts—what we term *warring identities*—have an important yet understudied effect on veterans' combat-related mental health problems.

Keywords

identity, military health, posttraumatic stress disorder, psychological distress, institutions

American veterans of the wars in Iraq (Operation Iraqi Freedom, or OIF) and Afghanistan (Operation Enduring Freedom, or OEF) face unique challenges related to post-deployment mental health and community reintegration (Sandberg, Bush, and Martin 2009; Sayer et al. 2010). It is estimated that as many as 41 percent of OEF/OIF veterans have at least one diagnosable mental health disorder (Hoge et al. 2004; RAND 2008; Seal et al. 2007). Although the psychological injuries suffered by OIF/OEF veterans are not dramatically new or different from earlier wars (Tanielian and Jaycox 2008), the repeated deployments and high-stress environments of OIF and OEF have resulted in significant physical and psychological consequences (Institute of Medicine 2008). Among the OEF/OIF veterans with combat experience, 51 percent reported difficulty readjusting to civilian life, twice the percentage of pre-9/11 veterans (PEW 2011). Of the OEF/OIF veterans who reported having traumatic experiences, 67 percent stated that their readjustment to civilian life after leaving the military was difficult (with 25 percent describing it as *very* difficult) (PEW 2011:52). The health of OIF/OEF soldiers has

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generated enough concern that even the former U.S. Secretary of Defense Robert Gates admitted that the consequences of troops' reintegration "terrify" him (Shanker 2011). Despite ever more evidence of a public health problem, little consensus remains about the primary cause aside from the obvious—warfare is not healthy.

In this study, rather than focus on soldiers' well-established mental health problems and attendant diagnoses, such as post-traumatic stress disorder (PTSD) or major depression, we examine the strain caused by the contrast between soldier identity—especially a soldier who has experienced combat—and the service member's postwar civilian identity.[1] Based on in-depth interviews with OIF and OEF veterans who have exited active duty and returned to civilian life, we examine how former soldiers make sense of their social circumstances given the military, combat, and postwar civilian worlds they inhabit at various points in time. We do not analyze disorders like PTSD, per se, but rather, examine how the identity conflict that arises after separation from military service can act as a catalyst for, or even present as, mental health problems. More specifically, we examine how identity strain manifests as mental distress in veterans; by mental distress we mean the range of experiences and symptoms of a person's internal life that are troubling or out of the ordinary but do not necessarily directly map onto psychiatric criteria-based diagnoses (Lynch et al. 2012). Whereas clinical perspectives are likely to view disorder as abnormal (and its origins in anomalous experiences or attributes), medical sociologists commonly view abnormality as a normal byproduct of the routine functioning of society. That is to say, distressing psychological states can be activated by aspects of social circumstances—or one's location within society—and this is a central focus of medical sociology (Aneshensel and Phelan 1999). Many studies examine prevalence and correlates of mental disorders among returning service members, as well as psychological distress experienced by their loved ones. Our work builds on this literature by analyzing the lived experiences of soldiers making the transition from military to civilian life in their own words. As such, we seek to broaden the discourse on psychological health of veterans to include those stressors and strains that matter most to veterans themselves.

After a discussion of the theoretical background and methods of our research, we describe how civilian society is frequently experienced as alienating and dislocating for post-deployment service members. Following this, we specify the intense identity transformation—starting with basic training—that occurs within individuals who enlist in the U.S. military. This initial transition is marked by the assimilation to a "total institution," which makes obedience, regimentation, and collectivism utmost priorities. This transformation of identity continues and extends for those soldiers who are deployed to a combat zone. Through soldiers' accounts, we illustrate how warfare's lethal context deepens the experience of the military's control, unit cohesion, and stoicism. We then turn to an analysis of veterans' emotional and social withdrawal as a response to exposures to violence and trauma; such withdrawal can be adaptive in the short term yet a conduit for psychological distress in the long term. Finally, we consider how reintegration to civilian society requires soldiers to navigate and interpret new ways of being in the social world. We contend that the struggle to resolve contrasting identities—what we call *warring identities*—during the readjustment transition plays a critical role in postwar mental distress of combat veterans.

Background

PTSD has become the most common military service–related mental health diagnosis of OIF/OEF veterans (Seal et al. 2007), affecting between 13 percent to 20 percent of this population (Institute of Medicine 2012).[2] Despite this prevalence, the diagnosis has been heavily critiqued for its problematic verifiability (Litz et al. 2009; Young 1995), expansion of traumatic criteria (i.e., conceptual "bracket creep") (Horwitz 2002a), and cultural proliferation (Summerfield 1999, 2001). In addition, even veterans without diagnoses like PTSD can experience distress because it is difficult to distinguish between distress and disorder and the boundaries are often vague and ambiguous (Horwitz 2007).

Our focus here, however, is not the specific trauma associated with having served during the current wars so much as it is the experiences that shape veterans' intersubjectivity and their effect on the civilian identities ex-soldiers must assume (or resume) when they return home. Since this study is based on a sample of combat soldiers, all of whom experienced at least some combat-related trauma, the study is informed by the years

of research that have found that "even traumatic or cumulative stress experiences do not necessarily result in psychological distress or disorder" (Thoits 2011:10). We understand distress as a "naturally selected response to stressful situations and *not* a genetic defect, a brain or personality dysfunction, or a mental disorder" (Horwitz 2007:213, italics added).

While several studies have examined the negative effects of illness on identity (Horwitz 2002a; Lively and Smith 2011), this study investigates the effects of identity conflict on mental health. Like Turner and Avison's (1992) work on chronic strains, we examine the meaning and impact of a non-discrete eventful stressor and how it has (or has not) been "resolved" (Turner and Avison 1992). The identity conflict we analyze is informed by (and can be extended) to studies of other life transitions. When people exit other total institutions, such as prisons or religious orders, they reenter a familiar, albeit altered, world that requires reestablishment of an identity in a new role that takes into account one's ex-role (Ebaugh 1988; Schein 1957). As Farrell and Rosenberg (1981) found with men's midlife crises, for example, distress is a consequence of the discrepancy between self-identity and former self-conceptions. Similarly, Burke (1991) finds that distress is a common outcome of such transitions because of the interruption of the identity process; it is a disruption of "the continuously operating loop of input meanings to output meanings."

Research on identity builds on the work of symbolic interactionists, who contend that social interaction is crucial to normal personality development and appropriate social behavior (Mead 1934). We draw from both medical sociology and social psychology—particularly the work of Peggy Thoits—to better understand how individual identity is fundamental to soldiers' postwar mental health. According to this model, identities are social categories that individuals learn in social interaction and accept as self-descriptive and self-defining (Thoits 2011). Identities are socially based answers to the question, "Who am I?," and they serve as sources of existential meaning or purpose in life (Thoits 1983, 1995).

Veterans confront identity crises like: "How have I changed?" and "Who is my new self?" In this regard, soldiers undergo a type of "narrative reconstruction" in which they reconcile the past and present to make sense of any illness (Williams 1984). Combat veterans' understandings of their identity as both soldiers and, later, as veterans affect mental health and well-being because "the circumstances in which events and strains occur shape their meaning by rendering them more or less harmful" (Simon 1997:257). Few studies, however, take into account the meanings individual soldiers attribute to their service (Kestnbaum 2009; Maclean and Elder 2007) even though the psychological effect of combat is shaped by how veterans perceive their combat experiences. Aside from a handful of studies like MacLeish's (2013) account of soldiers based at Fort Hood, most of the research fails to consider "the host of ideational processes—cognitive, evaluative, and even emotional—that get at how individuals make sense of themselves and of the world in which they live and the variety of ways these efforts at sense making may shape and be shaped by warfare" (Kestnbaum 2009:238). In-depth interviews with subjects—like those analyzed herein—reveal interpretations of stressors. This is important because psychological impacts of stressors are influenced by their meanings to the individual and these meanings can vary considerably (Thoits 2011). Like Kathy Charmaz's (1983) research on illness shows, interpretations shape the ways that individuals respond to events and circumstances, regardless of the objective reality of the event itself.

A crucial consideration of identity research is role centrality, the importance an individual places on a specific role that he or she has. Unlike veterans of earlier U.S. conflicts, OIF/OEF veterans serve within the all-volunteer Armed Forces, none have been conscripted. Most join the military with enthusiasm for the prospect of improving themselves and/or contributing in some fashion to something larger than themselves. It is not uncommon to voluntarily redeploy—sometimes even those who have suffered serious physical injuries do so—and most have few regrets about doing so. A remarkable 84 percent of all post-9/11 veterans who served *in a war zone* would advise a young person to join the U.S. military (PEW 2011); moreover, 69 percent of U.S. veterans (of all eras) who were *seriously injured* while serving would urge a young person to enlist (PEW 2011).

Combat deployments can be strenuous, sometimes traumatic, but the identity strain of post-deployment reintegration is mediated by the fact that being an ex-soldier is a highly salient, positively associated role identity. As the military

health researcher Charles Hoge (2011:549) found, OIF/OEF soldiers "are members of professional workgroups, similar to police and other first responders, trained to respond to multiple traumatic events; they do not normally perceive themselves as victims, nor their reactions as pathological." The (former) soldier identity remains an important self-conception and this affects health because stressors that harm or threaten individuals' most valued self-conceptions should be seen as more threatening and thus more predictive of psychological distress or disorder than those affecting less cherished aspects of the self (Thoits 1991, 1995).

Experiencing hardship within an identity that has positive associations and is longer term—unlike other threatening incidents (e.g., rape or car accident)—means combat can be what Thoits (1991) calls an "identity relevant experience" because it enhances an identity that an individual values highly. As a highly valued identity, the emotional impact of stressors related to this identity is all the stronger (Burke 1991; Thoits 2011). Although Thoits (2011:7) found that tests of the "identity-relevant stress" hypothesis have varied findings, others find that when an identity is highly salient, individuals may find themselves engaging in behavior associated with this identity even when it is not appropriate (Stryker 1980).

Methods

The article draws on one-on-one interviews conducted with 26 U.S. combat veterans of the wars in Iraq and Afghanistan. Interviews were conducted separately by the two authors, and the sample was combined for the purpose of data analysis and theory development. The first author conducted 12 interviews (between the fall of 2009 and the end of 2011) with veterans who were *not* routinely receiving health care through the Department of Veterans Affairs (VA) at the time of the interview; the remaining 14 interviews were conducted by the second author (between April 2009 and March 2010) with veterans who were receiving health care services at a VA Medical Center (VAMC). Interviews from the first author's sample lasted between two and four hours each and were conducted in a public setting that offered some privacy (e.g., quiet spot within a café). The first author's work was reviewed and approved by the Rutgers University Institutional Review Board (IRB); all participants signed a written informed consent.

The second author conducted interviews in a private office on the VAMC campus; she met with each veteran over two to three sessions for a total of four to five hours. The second author's work was reviewed and approved by the Philadelphia VA Medical Center IRB; all participants signed a written informed consent.

For the second author's study, veterans were only eligible for participation if they had a diagnosis of PTSD or major depression documented in their electronic medical record through the Veterans Health Administration. The first author did not have access to participants' medical records and relied on self-report of having received a diagnosis of PTSD; a majority of veterans in his study reported having received such a diagnosis from the VA or a health care provider. Nevertheless, in this article, we identify a social process that causes serious distress that may or may not prompt PTSD (or major depression) symptoms, let alone result in a mental health diagnosis.

Both authors used a semi-structured interview guide consisting of nondirective, open-ended questions to elicit veterans' experiences with military service, deployment(s), and post-deployment. Typical prompts included: "Tell me about your experience while deployed," "Whom, if anyone, do you speak to about your war experiences?" "What, if any, issues have you been dealing with since your return?" The interview guide was not rigidly followed; instead, a process of reflecting back language used by the interviewee and probing for clarification or additional details. All interviews were audio-recorded and transcribed verbatim; transcripts were imported into qualitative data analysis software to aid in management and coding of the data. All names used in the text are pseudonyms.

Across the total sample of 26, all four major branches of the active duty military (Army, Navy, Air Force, Marines) are represented; 16 had served in the National Guard or Reserves for all or part of their military careers. All of the participants served at least one deployment in support of OIF or OEF; 14 had been deployed to either Iraq or Afghanistan more than once. For a majority of the sample, interviews took place more than a year after they had returned from their last deployment. The participants were demographically representative of the current U.S. military forces. Twenty of the veterans were 22 to 39 years of age; the other six were 40 to 48 years old. Five of the veterans were women. Twelve self-identified as members of minority

groups: 7 African American, 3 as Asian American, 1 as Latino, and 1 as Muslim American of mixed race; the remaining 14 were non-Hispanic whites.

Nearly all of the participants (24) were Marines or Army infantry soldiers who experienced combat and earned commendations like the Army's CIB (Combat Infantry Badge). The sample does not include service members whose deployments were completely removed from harm (e.g., satellite communication engineers in Bahrain). It should be noted that there is no singular OIF or OEF experience, even for those who share the same branch of service, rank, and MOS (Military Occupational Specialty) so even when these categories are held constant, experiences can greatly vary because of when and where one is deployed. In fact, there is no clear estimate for the number of "combat" soldiers. Lastly, we cite three embedded journalists whose firsthand experiences with these wars contribute crucial insights on combat identity.

FINDINGS

The Context of Post-deployment Reintegration

A significant demographic shift now shapes veterans' experiences—the growing divide between civilians and soldiers. Since the end of the Cold War there has been a 36 percent reduction in the size of the military (Dorn et al. 2000) and the civilian-military gap widened in partisan and ideological identifications between 1976 and 1996 (Holsti 1999). The size of the active duty force has decreased to the point where those serving in active duty now number only 1.5 million. Iraq and Afghanistan are long wars—Afghanistan being the longest in United States history—fought by the smallest percentage of the American population. Not surprisingly, some service members refer to themselves as "the less-than-one-percent." According to a 2011 PEW report, 84 percent of the post-9/11 veterans state that the American public does not understand the problems faced by those in the military (PEW 2011:2).

Brian expressed his experience of this marginalization. "I kept hearing, 'You're just like the other OEF/OIF [veterans] who are transitioning.' And I'd say, 'Really? Well, where are the rest of them? I'm pretty sure I'm here alone, an alien.'

That's how I'd explain it to everyone—I am the alien." OIF/OEF veterans feel marginalized in many communities today because, indeed, they are; most citizens who do not have family or friends serving in the military have no interpersonal understanding of recent veterans' experiences aside from media depictions. The 2011 Pew report found that "there are now fewer connections between the military and the civilian world." Chairman of the Joint Chiefs of Staff Admiral Mike Mullen echoed this same concern: "[W]e in uniform do not have the luxury anymore of assuming that our fellow citizens understand [military life] the same way. . . . I fear they do not know us. I fear they do not comprehend the full weight of the burden we carry or the price we pay when we return from battle" (Mullen 2011).

For Bill, who joined the military at age 18, this disconnect has meant that he has "nothing in common with my old friends from high school." It is an immensely important part of his life, yet one very hard to convey. "That's one of the biggest things about being in the military; anytime I came home on leave, I just felt so detached from everyone I knew before, like I had nothing in common with them. I couldn't relate; I couldn't be myself. They said I had changed; I wasn't the person they remembered."

Another feature of the civilian context is that the military's system of meaning and recognition has been replaced. The military has many forms of bestowing recognition, such as the commendation of medals; however, these symbols are recognized only as far as the military culture extends. In the eyes of the average civilian (i.e., minimal military familiarity), such awards usually mean very little, if anything at all. As Eric stated, the "Combat Infantry Badge [CIB] is a great award because that means I did my job as an Infantryman. As an Infantryman I was engaged. I killed. And I destroyed the enemy [and] in the military that's celebrated . . . you have certain clout in the military because you have the CIB. But when you come into the civilian life, I can't wear that CIB on this sweater. Nobody cares." So the recognition achieved as a soldier is not fungible—what a soldier has worked hard to achieve, and survive, is rendered nearly meaningless. The process is akin to Goffman's (1961:73) description of the exit from prison: "release is likely to come just when the inmate has finally learned the ropes on the inside and won privileges that he has painfully learned are very important . . . release [from the

total institution] means moving from the top of a small world to the bottom of a large one." In the case of veterans, many former soldiers are cast adrift within civilian relationships and settings that have decreased familiarity with the military's symbols of recognition.

The converse can also be true, as when veterans are stereotyped in the media and other public spheres as symbols of heroism and self-sacrifice. For many soldiers, the burden of fitting the mold of the heroic fighter can be similarly dissonant. The lauded aspects of the former soldier identity are not automatically valued when communing with new people in a new setting, but as Nate stated, even when one's endurance is venerated, it can be burdensome to maintain the identity that others associate with you. "I can't be weak around them, you know, 'cause they all look at me as like some kind of like superman, you know. . . . They just see me as like this strong person that's made it through so much." This is evidence of the distress experienced when individuals receive feedback that is incongruent with their identity even if the feedback is more positive (Burke 1991).

Collectivism and "Ownership" of the Total Institution

When an individual enters the military, he or she undergoes a disciplining process that systematically strips each soldier of his or her individuality and agency. The transition is formidable because the military is a "total institution" with high levels of social integration, regimentation, and social control. Starting with basic training, the military instills in its recruits the idea that they have sacrificed their own agency and individuality for the sake of the larger collective. These "admissions procedures" strip the recruit of his or her attachment to his or her civilian self (Goffman 1961).

Wendy, a 38-year-old Army National Guard veteran, described the relationship in terms of ownership and property. "If you've been in the military you kind of have a different idea of what's private, what's yours. You can't say 'Oh, I think I'll pass on that inoculation,' or 'Oh, I think I've had enough flu shots.' [Laughs] Oh no, they *own* you . . . you really aren't even yourself. [Your body] belongs to the military."

Mike, a 29-year-old who was active duty for five years and in the reserves for two, explained

how the Marines' emphasis on being part of a team contrasts with civilian realities: "I went to Annapolis for college, and your grades are the only thing that is your own—everything else is part of a team. Your entire time in the military, nothing you do is for you, nothing you do is about yourself. Everything you do, everything you are, belongs to the Marines. Then you get out of the military and you try to integrate back—you do integrate back into the civilian world, but you quickly realize that nobody else is thinking that way, nobody else is thinking that everything they do is for a team. It is just for them."

The military's strict rules of behavior—detailed in the *Uniform Code of Military Justice* and other field manuals—guide soldiers' behavior so strictly that very little free will remains, especially for those who are of lower rank as the majority of soldiers (i.e., lower than E5 rank). Soldiers must follow orders in accordance with the chain of command. For most, as Brad explained, "you're told what to do, when to do it, and how to do it." Questioning orders is discouraged, if not illegal, and obedience to authority is woven into the service member's identity. The control over the individual, coupled with the penalty for exercising autonomy, conditions the soldier to forgo the seeking of further information. "Don't ask questions," said Phillip, a 26-year-old former Marine cannoneer. "Questions are bad. Anytime I've asked questions in the military, bad things happen afterwards. So just don't ask any questions." Phil, a former combat engineer in the Navy, expressed a related sentiment about seeking guidance: "The military never, ever, tells you how to ask for help."

Manuel, who enlisted at age 18, conveyed the effect of joining at such a young age. "I grew up there. That's why it was hard when I got out, because the military's all I knew." While the total institution is now part of his past, it remains acutely present. The process of sorting out one's *self* is usually more formidable in these instances (than it may be for the 40-year-old parent and spouse) because the self-conceptualization process has a less established foundation to build upon, and young recruits are less likely to have the same network of civilian social support. Most who join the military serve for only four years, and 50 percent of all forces (all branches together) are between the ages of 17 and 24 (Kelty, Kleykamp, and Segal 2010). Since they are less likely to be parents, spouses, or full-time wage earners,

their soldier identity (and potential combat experience) represents a greater identity salience and its potential psychological impact is therefore greater (Thoits 1992). This disproportionate effect of age has been found in young single male service members who are of lower rank (Iversen et al. 2005) and corroborated by Gibbons, Brown, and Hur's (2012) research that found a higher suicide rate among younger veterans than older veterans.

A corollary of the military's collectivism is the provision of each person's most fundamental needs. Necessities like food, shelter, electricity, heat, clothing, education, hygiene, and basic health care are supplied and can generally be taken for granted. As Eric, the 28-year-old Army National Guard veteran, stated, "There are no groceries I have to buy [or] bills I have to pay." The support that comes from the provision of such basic necessities is often not fully appreciated until soldiers have left the military.

All of these aforementioned dimensions of military identity—order, obedience, and collectivism—serve the military's larger objectives and allow it to carry out its mission. At the same time, they conflict with many dimensions of an integrated civilian identity.

Combat Identity

As a total institution, the military nearly dictates a service member's sense of self, yet deployment to a combat zone further imprints the soldier identity. The soldier "has returned from twelve months in which he experienced intense fellowship within a military unit that became his de facto family. Mutual interdependence, trust, and affection forged in the crucible of ongoing life-threatening combat [have] altered his sense of personal and social identity" (Friedman 2006:587). Since the soldier identity is further internalized, those service members returning from deployment find the transition to civilian life to be more intensive than it is for soldiers who have never deployed. Life course research on veterans finds that across all eras combat veterans have had worse health than noncombat veterans and nonveterans (Maclean and Elder 2007).

Having been extensively trained for combat and steeped within a culture that highly esteems real combat (over training), most soldiers hope for deployment to a combat zone. For many service members, being deployed equates to what

Trent, the 40-year-old Army infantryman, called "living the dream." While the actual experience is often different from what they envisioned—and some tours certainly become nightmares—combat allows one to make good on a cherished ideal: the battle-tested soldier who has survived war. In fact, soldiers lacking combat experience often feel an unfulfilled void that plagues their sense of self—a kind of "spoiled identity" (Goffman 1963) stemming from a perceived failure to achieve "true" veteran status. While our sample includes only soldiers who have experienced combat, longing for deployment is commonly expressed by soldiers, especially those who have volunteered to serve (unlike the conscripted of earlier times).

Although counter-insurgencies like OIF and OEF often have uncertain missions, social rewards that reinforce the soldier identity come from deployments. Veterans emphasized the intensity of bonds formed with fellow soldiers and the meaning found within war. Much of what the veterans we interviewed conveyed to us about their experiences resonates with a claim by Sebastian Junger (2010:144), an embedded war journalist: "Twenty minutes of combat is more life than you could scrape together in a lifetime of doing something else." In a lethal context, actions have immediate, oftentimes immense, consequences. The danger generates a hard-to-match visceral experience that tests oneself like nothing else. For the majority of interview participants, war is an experience where few things are taken for granted and any hardship usually has identifiable, tangible precipitants.

Combat's danger makes the potential for solidarity—"unit cohesion" in military parlance—even more intensive. The strains of a lethal context engender the possibilities for deep caring and love for one another (despite the stoicism that otherwise permeates the military). Soldiers sometimes refer to the relationships they forge as being family-like. "I got a lot of love there," Manuel stated. "I met some really good people, some people who really cared about the troops and about people in general." More than demonstrating a seeming paradox between the military's hypermasculinity and caring masculinities (Green et al. 2010), their love for one another is among the most compelling rewards of serving.

Despite being subject to the vagaries of improvised explosive devices (IEDs)—which not only instill a sense of uncertainty but are responsible for roughly 80 percent of all casualties—war for

some OIF/OEF soldiers is experienced as a feeling of confidence and control. Some even referred to the experience as one of "safety." Manuel, for example, found war to be a "safe zone" that he never wanted to end. "I just felt like . . . these guys were like my family. I never wanted that deployment to end. We were together for so long. . . . And that deployment, with those guys, that was just a *safe* zone for me. Whenever we'd go on convoys, I'd feel so confident because I'd know I was with a team of guys that, either we were all going to die together, or else no one would die." Dan, who served in the Army National Guard, shared this sentiment. He explained the conflict he felt over his strong urge to be deployed again and his wife's relief at having him home safe. He relayed a story about confiding to his Guard unit his desire to redeploy and the surprise he felt when they admitted that they too missed the camaraderie and sense of safety experienced during deployment. For Manuel, Dan, and most veterans in our sample, the risks of war are not individualized but subsumed in and by the group; in the midst of radical danger, the military unit provides a sense of near transcendental safety. We argue that these lethal experiences, and the counterintuitive reconfiguration of safety derived from such solidarity, crystalize the soldier identity.

In combat, one is trained to be ready to kill, and stoicism in the face of violence is required. Donovan Campbell, a Marine who is also an author, sums up this disposition when he explains his experience as a combat leader in Iraq. "[You] must have no concern for your own safety . . . you can only pretend that you are already dead, and thus free yourself up to focus on [other] things" (Campbell 2009:5). David Finkel, a journalist embedded with an Army battalion, recorded the advice of a chaplain who counseled troops during the 2007 Iraq surge. "If you are not ready to die," the chaplain implored, "you need to be. If you are not ready to see your friends die, you need to be" (Finkel 2009:12). Such admonitions illustrate a prevailing doctrine of preventive battlefield medicine: soldiers should deny the capacity to fully live. Thinking expansively, being relational, and envisioning the future is discouraged, for such mental dispositions make soldiers more vulnerable. Extreme emotional control and a significant degree of dissociation are essential to the identity of soldiers who experience violent combat deployments.

Evan Wright, an embedded journalist in Iraq, explains the process of such dislocation in the following account of behavior immediately before a battle: "It's best to shut down, to block everything out. But to reach that state, you have to almost give up being yourself. This is why, I believe, everyone said good-bye to each other yesterday before leaving on this mission. They would still be together, but they wouldn't really be seeing one another for a while, since each man would, in his own way, be sort of gone" (Wright 2008:300). Although crucial for survival, this transformation is not without consequences; shutting down repeatedly (and to the extreme degree described) means to "give up being yourself." This is a type of identity dislocation—losing touch with whom you are, subsuming one's self in the larger identity of the group.[3]

Autonomy Adjustment

Leaving the military after a recent deployment means adjusting to a new sense of autonomy. The transition out of the military is commonly experienced as overwhelming, uncertain, and anomic, especially immediately following combat. Behavior is suddenly voluntary and the lack of regimentation (and larger sense of purpose) is a basis of distress. Becoming a civilian again means reestablishing that "he has some command over his world—that he is a person with 'adult' self-determination, autonomy, and freedom of action" (Goffman 1959:43).

For Trent, age 40, the lack of regimented structure upon return was so disorienting that he did not leave his house for the first month. "When I came back, I stayed in the house for like 30 days straight. . . . I didn't realize I can leave. *I could go out*. Because you're so used to being regimented like being on the base and people telling you to come and go, I had to remind myself that I could just leave. I didn't have to stay in the house."

"On the outside," Manuel explained, "you get into trouble and you get dealt with and that's it. In the military, you get into trouble and you've got people who want to get you help, who are concerned." While the military's unit cohesion can contribute to harmful outcomes, even suicide (Braswell and Kushner 2012), civilian life is generally experienced as if no comparable level of social support exists. Brandon's testimony about

his trials following deployment corroborated this sea change: "You are on your own; no one notices when you're falling apart." Sharon summarized her experience of returning after three years of service and realizing that she too was on her own: "You have to start all over again. . . . The military life is very different from civilian life. A lot of people in the military have been in since high school, and they get out and they're lost. They are used to having someone tell them what to do, and now they have to do for themselves. You don't have a support system, unless you have a family."

The need to be independent after experiencing strong group ties and intensive social control is a basis for distress. Day-to-day civilian tasks require an individual's autonomy, and the collective support that infused deployment is no longer an inherent part of one's experience. Certain tasks that never occur during combat—such as disputing a bill with a collection agency—present stressors given their complexity and/or the need to fight for oneself. In this regard, combat veterans experience "disculturation," the loss or failure to acquire some of the habits currently required in the wider society (Goffman 1961:73).

As Laura, the 25-year-old Air Force veteran stated, "Soldiers are trained to be self-reliant, but not self-advocate." This self-sufficiency and obedience of the soldier habitus make for a type of "double-bind" (Bateson 1972): soldiers must be self-sufficient and take care of themselves while also being subject to others' orders. Following the chain of command is essential; challenging it is grounds for being court-martialed.

Many soldiers encounter the feeling of being overwhelmed by post-deployment options. "I'm having a tough time deciding what I want to do in life, what I want to be," Manuel stated. "I could live anywhere, do anything." This "paradox of choice" (Schwartz 2005) is almost inevitable given the plethora of options and the absence of binding authority within civilian society.

Disconnection from Civilian Relations

In the current wars, most soldiers can maintain communication with close relations back in the States. Albeit from a distance, retaining some element of their role as partners and family members is common, especially for those soldiers who are parents—some 40 percent of the army according

to a 2007 Institute of Medicine study (Institute of Medicine 2010). Consider how Heidi Kraft, a clinical psychologist who served in OIF, struggled with the task of serving while maintaining her identity as a mother. Ultimately she ended communication with her family because she realized that she "would be unable to function in Iraq if my children stayed at the forefront of my consciousness . . . I decided I could not be a combat psychologist and mother at the same time. I had to be one or the other" (Kraft 2007:35).

Hence, veterans struggle to emerge from the deployed soldier identity that has distanced them from their civilian relationships. As Mike stated, "I could not afford, for their sake or for mine, to let [my family] dominate my thoughts. I had men and women depending on me for their lives. . . . Some families say, 'Well, I thought of you every waking moment.' [But] as a soldier you can't afford to think of them every waking moment—you could get killed or, worse, you could get someone else killed." This compartmentalization process means that even when lines of communication are available—and a deployed soldier is in the position to offer familial or relational support—he or she may not. A partner's physical distance is not necessarily ameliorated by modern communication technology given that *social* distance is an endorsed coping strategy for soldiers under duress.

Since self-concepts and self-evaluations are socially derived and socially sustained (Thoits 2011), a veteran's identity process during reintegration gets stunted by the withholding of information and experiences from civilian acquaintances. Soldiers' relationships with civilians are further strained because, in part, returning soldiers rarely discuss their combat experience, usually keeping their stories and memories to themselves. As Nate, a 27-year-old who was severely injured in Afghanistan, stated, "I usually avoid talking about my deployment. It's hard to know how to talk about it, or who to talk to . . . so you can get kind of stuck. It's always hard to let people in, to tell people who weren't there about what happened." Veterans perceive civilians as being naïve, misinformed, or even worse, judgmental. They might avoid or redirect the subject if it comes up because most soldiers find that sharing the experience (in a way that provides them any satisfaction) is not worth the energy and time required.

This silence even applies to the people with whom veterans spend most of their time—family

members and significant others. Within intimate relationships, for example, veterans ordinarily avoid sharing feelings (and details) about their war experiences. Often veterans do not know how to tell their stories nor whom to tell them to. As Brandon explained, about his girlfriend of 10 years, "She doesn't really understand . . . I mean, we've had some conversations, but nothing real big." This gap in shared information is usually characterized as a form of protection for their relations, although arguably a defensive strategy that prevents veterans from confronting the feelings themselves. At the same time, this silence maintains the social distance and decreased intimacy between veterans and their close relations (Monson, Taft, and Fredman 2009). Importantly, because individuals acquire conceptions of themselves as meaningful social objects via role-taking (Thoits 1992)—with, for example, civilian partners—the lack of shared knowledge *reinforces* their ex-soldier identity as the (subsequent) civilian identity process has been curtailed. Bill conveyed that he and his wife talk, but "she knows me better than I know myself. I don't know myself; I don't try to, I don't look inside, I don't care what my reasons are for doing anything."

In Danny's case, he feared upsetting his family, the group he had been most dependent upon for social support before deploying. "I didn't want to see my family at first. You don't know who you are any more, and you're not back to who you were. And you're afraid you're gonna scare them." Paul gave an account of his efforts to conceal his war experiences from his wife. His attempt rested on denying the reality of his former self: "I won't tell [my wife] about what I did there. I don't want people to feel pity for me. She might think of me in a different way. She might think, 'You're somebody that's capable of killing; you did it before. You killed somebody.' It's hard for someone who wasn't there to see the difference between what you did there and how you are at home. They think it's like the movies." Despite the United States fighting two recent wars—one of which is the longest running war in U.S. history—and aside from popular media depictions, most American civilians, even the intimate partners of soldiers, know very little about what war actually entails (Makin-Byrd et al. 2011; Sherman, Zanotti, and Jones 2005).

Paul tried to convey his warfare experiences to his wife, but he felt that his efforts were met with judgment. "I've tried telling my wife about things

before, but then I see the different look in her eyes and I stop. I'd rather have her know me like I am now than what I was like over there." Since identity is constructed within "continuously operating, self-adjusting feedback loops" (Burke 1991:840), gaps in their understanding about deployment experiences leave veterans tied even more to their soldier identities.

Social Support and Social Withdrawal.

Another feature of the conflicting identities is characterized by the experience of being out of control and destabilized by new structures of recognition. Social control and mastery—"the extent to which one regards one's life chances as being under one's control in contrast to being fatalistically ruled" (Pearlin and Schooler 1978:5)—is key to mental health recovery and stability (Pearlin and Schooler 1978; Thoits 1995). Yet the postwar world is often experienced as uncertain and disordered; moreover, the former markers of status and recognition no longer hold in a civilian world.

Social withdrawal is a response to the feeling of being out of control. Even if it satisfies an urge for greater control, veterans' withdrawal, however, limits both assimilation and civilian understanding of their experience. Significant partners, family members, coworkers, friends, classmates, and fellow veterans ordinarily play a critical role since they come in greatest contact with the returning soldier. However, regardless of how large or caring the network of support, veterans usually withhold a deep store of muddled feelings that are difficult to communicate. Ambivalence about their military service is very common because pride mixes with "full recognition of the sacrifices and moral ambiguities involved in offering up one's life and will to a global superpower in a time of war" (Finley 2011:28). Similar to what Arlene Stein found in her work on Holocaust trauma, "survivors made choices about which parts of their former identities they would maintain," alter, disclose, and hide; and these varied "according to whom they were talking, the circumstances of the interactions, and the individual proclivities" (Stein 2009:57).

Frustration can easily convert to anger for those who have no institutionalized outlet to express/work through their emotions and ambivalence. The anger—and the reaction of others *to* the anger—are experiences that recently returned combat veterans learn to navigate. Sharon

described her anger in terms of a fear of self: "After coming back from Iraq, I would have fits and yell and throw things at my husband. I wanted to escape. I'd have a panic attack just trying to get a cup of coffee at Wawa. I had no name for what I was feeling, so it just turned into anger. What I didn't realize was that I was really afraid of this world—the civilian world—afraid of myself in this world." For a group of people who are accustomed to order, control, and stoicism, this instability of feelings can trigger a newfound apprehension of oneself. Uncertainty over how one *might* behave in social settings is concerning because it is the antithesis of the control and mastery that have proven to be helpful in terms of coping with mental health problems.

Tom explained the effect of social withdrawal on his civilian relationships: "I haven't been in a decent relationship since I've been back . . . emotionally, I feel detached sometimes. It's just weird. I'm just hardly fazed by stuff." When asked if he is comfortable going out and accepting invitations, Tom elaborated:

> "Comfortable" might be overstating it a little bit. Uh, I accept it. Like I say, okay, this is what it is. But at the same time, I'm already saying—I'm already limiting myself. I'm only gonna stay this long. I'm gonna have one drink. And I'm not gonna get drunk for nobody. I'm not, you know, losing control. So, I keep my composure and nothing bad happens. . . . Like if you don't put yourself in [social] situations, then the probability . . . of something bad happening stays low. . . . I just feel so much better when I'm by myself 'cause I have control. There's no variables.

While there is a function to his social isolation—it is a beneficial adaptation for those who do not trust themselves in social situations—Tom's behavior demonstrates the vigilant management of his civilian identity within the post-combat world. As he adopts new ways to keep his temper in check, he inadvertently causes even greater social isolation, further limiting his possibilities for social support in a community in which veterans already experience low social integration. A more easeful readjustment is therefore hampered by his failure to feel a sense of control and mastery, which partly stems from the debilitating feeling of being misunderstood.

DISCUSSION AND CONCLUSIONS

In this article we argue that combat veterans' mental health is strained by the identity conflict experienced during postwar reintegration. Instead of focusing on veterans' mental health problems strictly as consequences of trauma—and the common diagnoses like PTSD that are associated with such—we investigate the psychological distress that is caused by a profound identity conflict. We find that the conflict that arises after separation from military combat service can act as a catalyst for, or even present as, mental health behavioral problems.

We do not suggest a direct causal link between the challenges of reestablishing identity in post-deployment and specific mental health disorders or outcomes. Instead, we show how an underexamined social process of identity conflict influences veterans' mental distress and community reintegration. Whereas clinical perspectives are likely to view disorder as abnormal (and its origins in anomalous experiences or attributes), we have identified a distressing psychological state activated by aspects of veterans' (more ordinary) post-deployment social circumstances. Although combat veterans reside in a place of relative tranquility upon return, they contend with existential questions about a changed identity that civilians rarely endure. We contend that this state of distress stems less from the immediate effects of combat than from the effects of identity processes, relationships, and social integration.

Although psychological wounds from war are nothing new, it is novel for combat soldiers to adjust within a society where the PTSD diagnosis is part of the everyday culture. We are not arguing that PTSD does not exist. (Nor do we advocate rolling back the gains that have been achieved through the recognition of PTSD as a serious war injury.) Instead, we contend that the PTSD framework that dominates studies of soldiers' postwar mental health fails to properly account for the wide range of veteran experiences. The disease-oriented view of PTSD research not only runs the risk of pathologizing soldiers, it fails to consider how an individual's transformed conception of self impacts mental health and well-being.

The research on OIF/OEF veterans' mental health almost exclusively concerns access, diagnosis, and treatment within formal institutions (e.g., VA hospitals, military hospitals, or military bases). Properly understanding a combat veteran's

mental health, however, means considering the former soldiers' interpretation of their service, combat, possible injuries, and postwar civilian experiences. Their interpretation of these experiences affects self-conceptions and has implications for one's stability, coping, and resilience. As Tom, the Army infantryman, clarified, "what I try to explain to people about war [is that] it's not the blood. People on the street see blood and guts. Blood and guts is not, you know . . . people go in the medical field, they see blood and guts. It's not hard to detach yourself from stuff like that, it's really not. You'd be surprised if you're around it enough. But that's not the thing. It's like how you felt about the experience. How you feel about yourself afterwards. And what it really meant to you then, and what does it mean to you now." This interpretation is by no means fixed, but rather a social process contingent on relationships, interactions, and social circumstances.

Related to this is the fact that most veterans are not diagnosed with a mental health condition, and almost half do not report any reintegration problems (Institute of Medicine 2012; Iraq and Afghanistan Veterans of America 2012; Pew 2011). We found, however, that across our two subsamples, combat veterans almost unanimously experienced the conflicting identities we have delineated. Some are more distressed by the conflict than others, and in general, the greater the commitment to the soldier identity, the more significant the strain. Those most subject to the strain are least likely to be in our sample because in most of these instances they choose to remain within the military (if possible). As one 48-year-old lieutenant colonel who did multiple deployments stated, "If I didn't have my family, I would have just gone back to Iraq. Because what do I have here if I don't have my family?" Those who stay in the military continue to identify as a soldier; they wear the uniform, shop at the PX, socialize with military personnel, access health care on base (as opposed to the VA), and possibly live on base with meals and housing and so on provided. However, injuries and other conditions can force people out, and these less-voluntary role exits are likely to generate the most distress.

The behaviors disciplined by the military coupled with the conduct necessary for warfare significantly differ from the behaviors required of autonomous civilians. In combat, one's existence is mission-directed, regimented, and focused on a common goal. Surviving a lethal context as a member of a total institution is arduous, although it offers relative structure, a sense of purpose, collective support, and a shared goal.

The strict regimentation, order, and hierarchy that is found (and required) within the military all but disappears upon return to the civilian world. The harsh adjustment demands that combat veterans relinquish their more black-and-white, dichotomized framework of enemy/ally, superior/subordinate, and replace it with a more autonomous, even anomic, civilian identity. This presents complicated social demands with more variables and negotiations; a context where self-advocacy is beneficial despite the impetus to do otherwise. Strangely enough, the radical contrast between combat soldier and civilian results in some soldiers feeling greater control in warfare than they do upon their return to civilian life.

In war, the sense of self has been converted to the sense of (bonded) selves—it is not individualized. The military (and combat) experience systematically breaks down a soldier's individualism and autonomy. The cohesion, discipline, and order can even instill the feeling of being owned by the institution. This experience is magnified by the dissociation and emotional withdrawal that warfare demands. In post-deployment, former soldiers must reacquaint themselves with their civilian loved ones (and a former self). The effort to make congruent one's identity and a sense of self is often agonizing because when individuals fail to achieve desired consistency (between situation and beliefs about self) they experience cognitive and/or emotional dissonance that gets manifested as distress (Charmaz 1983; Elson 2003; Lively and Smith 2011). This has significant implications for mental health because social support is such a crucial buffer to psychological distress (Kessler and McLeod 1985). Meanwhile, today's Iraq and Afghanistan combat soldiers must do this within a larger society in which he or she feels increasingly marginalized and misunderstood, even "alien."[4]

AUTHORS' NOTE

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NOTES

1. We use the term *soldier* although we recognize that service members themselves may identify as Marine, Airman, and so on.
2. PTSD is an anxiety disorder that entered the *Diagnostic and Statistical Manual of Mental Disorders III* (*DSM*) in 1980 after a struggle for the recognition of veterans' psychological wounds (Scott 1990). Recent Veterans Affairs data show that from 2004 through 2008, the number of unique veterans receiving treatment for PTSD increased by 60 percent (from over 274,000 to over 442,000) (GAO 2011). A study of six years of data from the Veterans Health Administration (VHA), published by the Congressional Budget Office in 2012, found that the cost of treating a typical patient with PTSD in the first year of treatment averaged $8,300. From 2004 to 2009, the VHA spent $3.7 billion on the first four years of care for all the veterans tracked by the study. Sixty percent of that sum, or $2.2 billion, went for the care of patients with PTSD or traumatic brain injury (TBI), or both (CBO 2012).
3. Dissociative defenses help individuals separate from the full impact of trauma when it occurs and they may delay the necessary working through and putting into perspective of these traumatic experiences after they have happened (Spiegel 1991). According to the *DSM*, dissociative identity disorder is a mental disorder in which a person's consciousness, memory, and identity appear fractured (Boysen 2011).
4. Since these two wars began there has been a significant rise in the veteran suicide rate and it is now higher than the civilian rate. According to recent reports, however, a relatively low proportion of veterans who committed suicide have experienced direct combat. The 2012 Department of Defense Suicide Event Report found that "direct combat experience" was reported for 15.3 percent of suicide decedents and 17 percent of suicide attempts (Luxton et al. 2012). LeardMann et al. (2013) have also found that none of the deployment-related factors (combat experience, cumulative days deployed, or number of deployments) were associated with increased suicide risk in any of their models. These recent findings we believe speak, in part, to the conflict we analyze; the transition from the soldier identity—forged within the military's total institution—into the civilian identity can serve as the basis for significant psychological distress.

REFERENCES

Aneshensel, Carol S. and Jo E. Phelan. 1999. "The Sociology of Mental Health: Surveying the Field." Pp. 3-18 in *Handbook of the Sociology of Mental Health*. Edited by C. S. Aneshensel and J. C. Phelan. New York: Kluwer Academic/ Plenum Publishers.

Bateson, Gregory. 1972. *Steps to an Ecology of Mind*. Chicago: University of Chicago Press.

Boysen, Guy A. 2011. "The Scientific Status of Childhood Dissociative Identity Disorder: A Review of Published Research." *Psychotherapy and Psychosomatics* 80:329-34.

Braswell, Harold and Howard I. Kushner. 2012. "Suicide, Social Integration, and Masculinity in the U.S. Military." *Social Science and Medicine* 74(4):530-36.

Burke, Peter J. 1991. "Identity Processes and Social Stress." *American Sociological Review* 56:836-49.

Campbell, Donovan. 2009. *Joker One: A Marine Platoon's Story of Courage, Leadership, and Brotherhood*. New York: Random House.

Charmaz, Kathy. 1983. "Loss of Self: A Fundamental Form of Suffering in the Chronically Ill." *Sociology of Health and Illness* 5(2):168-95.

Congressional Budget Office. 2012. "The Veterans Health Administration's Treatment of PTSD and Traumatic Brain Injury among Recent Combat Veterans. Congress of the United States. A CBO Study." Retrieved November 13, 2013 (http://www.cbo.gov/sites/default/files/cbofiles/attachments/02-09-PTSD.pdf).

Dorn, Edwin, Howard D. Graves, Joseph J. Collins, Walter F. UlmerJr. Jr., and Thomas Owen Jacobs, eds. 2000. *American Military Culture in the Twenty-first Century: A Report of the CSIS International Security Program*. Washington, DC: Center for Strategic and International Studies.

Ebaugh, Helen Rose Fuchs. 1988. *Becoming an Ex: The Process of Role Exit*. Chicago: University of Chicago Press.

Elson, Jean. 2003. *Am I Still a Woman?: Hysterectomy and Gender Identity*. Philadelphia, PA: Temple University Press.

Farrell, Michael P. and Stanley D. Rosenberg. 1981. *Men at Midlife*. Boston: Auburn House.

Finkel, David. 2009. *The Good Soldiers*. New York: Farrar Strauss and Giroux.

Finley, Erin P. 2011. *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan*. Ithaca, NY: Cornell University Press.

Friedman, M. J. 2006. "Posttraumatic Stress Disorder among Military Returnees from Afghanistan and Iraq." *American Journal of Psychiatry* 163(4):586-93.

GAO. 2011. "VA Spends Millions on Post-traumatic Stress Disorder Research and Incorporates Research Outcomes into Guidelines and Policy for Post-traumatic Stress Disorder Services." Washington, DC: United States Government Accountability Office.

Gibbons, Robert D., C. Hendricks Brown, and Kwan Hur. 2012. "Is the Rate of Suicide among Veterans Elevated?" *American Journal of Public Health* 102 (S1):S17-19.

Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday.

Goffman, Erving. 1961. *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*. Garden City, NY: Anchor Books.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Prentice-Hall.

Green, Gill, Carol Emslie, Dan O'Neill, Kate Hunt, and Steven Walker. 2010. "Exploring the Ambiguities of Masculinity in Accounts of Emotional Distress in the Military among Young Ex-servicemen." *Social Science and Medicine* 71(8):1480-88.

Hoge, Charles W. 2011. "Interventions for War-related Posttraumatic Stress Disorder: Meeting Veterans Where They Are." *Journal of American Medical Association* 306(5):549-51.

Hoge, Charles W., Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert L. Koffman. 2004. "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care." *The New England Journal of Medicine* 351(1):13-22.

Holsti, Ole R. 1999. "A Widening Gap between the U.S. Military and Civilian Society?" *International Security* 23(3):5-42.

Horwitz, Allan. 2002a. *Creating Mental Illness*. Chicago, IL: University of Chicago Press.

Horwitz, Allan. 2002b. "Outcomes in the Sociology of Mental Health and Illness: Where Have We Been and Where Are We Going?" *Journal of Health and Social Behavior* 43:143-51.

Horwitz, Allan. 2007. "Transforming Normality into Pathology: The *DSM* and the Outcomes of Stressful Social Arrangements." *Journal of Health and Social Behavior* 48(3):211-22.

Institute of Medicine. 2008. *Gulf War and Health. Vol. 6. Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress*. Washington, DC: The National Academies Press.

Institute of Medicine. 2010. *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*. Washington, DC: The National Academies Press.

Institute of Medicine. 2012. *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Initial Assessment*. Washington, DC: The National Academies Press.

Iraq and Afghanistan Veterans of America. 2012. "IAVA Member Survey." Retrieved October 3, 2013 (www.iava.org/iavas-2012-member-survey).

Iversen, Amy, Claire Dyson, Naomi Smith, Neil Greenberg, Rebecca Walwyn, Catherine Unwin, Lisa Hull, M. Hotopf, C. Dandeker, J. Ross, and S. Wessely. 2005. "'Goodbye and Good Luck': The Mental Health Needs and Treatment Experiences of British Ex-Service Personnel." *The British Journal of Psychiatry* 186(6):480-86.

Junger, Sebastian. 2010. *War*. New York: Twelve.

Kelty, Ryan, Meredith Kleykamp, and David R. Segal. 2010. "The Military and the Transition to Adulthood." *The Future of Children* 20(1):181-207.

Kessler, Ronald C. and Jane D. McLeod. 1985. "Social Support and Mental Health in Community Samples." Pp. 219-40 in *Social Support and Health*, edited by S. Cohen and S. L. Syme. San Diego, CA: Academic Press.

Kestnbaum, Meyer. 2009. "The Sociology of War and the Military." *Annual Review of Sociology* 35: 235-54.

Kraft, Heidi S. 2007. *Rule Number Two: Lessons I learned in a Combat Hospital*. New York: Little, Brown and Co.

LeardMann, Cynthia A., Teresa M. Powell, Tyler C. Smith, Michael R. Bell, Besa Smith, Edward J. Boyko, Tomoko I. Hooper, Gary D. Gackstetter, Mark Ghamsary, and Charles W. Hoge. 2013. "Risk Factors Associated with Suicide in Current and Former US Military Personnel." *JAMA* 310(5):496-506.

Litz, Brett T., Nathan Stein, Eileen Delaney, Leslie Lebowitz, William P. Nash, Caroline Silva, and Shira Maguen. 2009. "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy." *Clinical Psychology Review* 29(8): 695-706.

Lively, Katherine J. and C. L. Smith. 2011. "Identity and Illness." Pp. 505-25 in *Handbook of the Sociology of Health, Illness, and Healing*, edited by B. A. Pescosolido, J. K. Martin, J. D. McLeod, and A. Rogers. New York: Springer Publishers.

Luxton, David D., Janyce E. Osenbach, Mark A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm. 2012. *Department of Defense (DoD) Suicide Event Reports*. Washington, DC: Department of Defense.

Lynch, Johanna M., Deborah A. Askew, Geoffrey K. Mitchell, and Kelsey L. Hegarty. 2012. "Beyond Symptoms: Defining Primary Care Mental Health Clinical Assessment Priorities, Content and Process." *Social Science and Medicine* 74(2):143-49.

MacLean, Alair. and Glen H. Elder. 2007. "Military Service in the Life Course." *Annual Review of Sociology* 33(1):175-96.

MacLeish, Kenneth T. 2013. *Making War at Ft. Hood: War and Uncertainty in a Military Community*. Princeton, NJ: Princeton University Press.

Makin-Byrd, Kerry, Elizabeth Gifford, Susan McCutcheon, and Shirley Glynn. 2011. "Family and Couples Treatment for Newly Returning Veterans." *Professional Psychology: Research and Practice* 42(1):47-55.

Mead, George Herbert. 1934. *Mind Self, and Society: From the Standpoint of a Social Behaviorist*. Chicago: University of Chicago Press.

Monson, Candice M., Casey T. Taft, and Steffany J. Fredman. 2009. "Military-related PTSD and Intimate Relationships: From Description to Theory-driven Research and Intervention Development." *Clinical Psychology Review* 29(8):707-14.

Mullen, Mike. 2011. "West Point Graduation Ceremony." Delivered by Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff, United States Military Academy, West Point, NY. May 21, 2011. Joint Chiefs of Staff website. Retrieved October 3, 2013. (http://www.jcs.mil/speech.aspx?id=1598).

Pearlin, Leonard I. and Carmi Schooler. 1978. "The Structure of Coping." *Journal of Health and Social Behavior* 19:2-21.

PEW. 2011. "The Military Civilian Gap: War and Sacrifice in the Post-9/11 Era." Retrieved October 25, 2011 (http://www.pewsocialtrends.org/2011/10/05/war-and-sacrifice-in-the-post-911-era/).

RAND Health and Center for Military Health Policy Research. 2008. *Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans*. Santa Monica, CA: RAND.

Sandberg, Mark A., Shane S. Bush, and Thomas Martin. 2009. "Beyond Diagnosis: Understanding the Healthcare Challenges of Injured Veterans through the Application of the International Classification of Functioning, Disability And Health (ICF)." *The Clinical Neuropsychologist* 23(8):1416-32.

Sayer, Nina, Siamak Noorbaloochi, Patricia Frazier, Kathleen Carlson, Amy Gravely, and Maureen Murdoch. 2010. "Reintegration Problems and Treatment Interests among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care." *Psychiatric Services* 61(6):589-97.

Schein, Edgar H. 1957. "Reaction Patterns to Severe, Chronic Stress in American Army Prisoners of War of the Chinese1." *Journal of Social Issues* 13(3):21-30.

Schwartz, Barry. 2005. *The Paradox of Choice: Why More Is Less*. New York: Ecco.

Scott, Wilbur J. 1990. "PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease." *Social Problems* 37(3):294-310.

Seal, Karen H., Daniel Bertenthal, Christian R. Miner, Saunak Sen, and Charles Marmar. 2007. "Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities." *Archives of Internal Medicine* 167:476-82.

Shanker, Thom. 2011. "Gates Warns against Wars like Iraq and Afghanistan." *New York Times*, February 25, p. A7.

Sherman, Michelle D., Dona K. Zanotti, and Dan E. Jones. 2005. "Key Elements in Couples Therapy with Veterans with Combat-related Posttraumatic Stress Disorder." *Professional Psychology: Research and Practice* 36(6):626-33.

Simon, Robin W. 1997. "The Meanings Individuals Attach to Role Identities and Their Implications for Mental Health." *Journal of Health and Social Behavior* 38(3):256-74.

Spiegel, David. 1991. "Dissociation and Trauma." *Review of Psychiatry* 10:261-75.

Stein, Arlene. 2009. "'As Far as They Knew I Came from France': Stigma, Passing, and Not Speaking about the Holocaust." *Symbolic Interaction* 32(1):44-60.

Stryker, Sheldon. 1980. *Symbolic Interactionism: A Social Structural Version*. Menlo Park, CA: Benjamin/Cummings Publishing Company.

Summerfield, Derek. 1999. "A Critique of Seven Assumptions behind Psychological Trauma Programmes in War-affected Areas." *Social Science and Medicine* 48(10):1449-62.

Summerfield, Derek. 2001. "The Invention of Post-traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category." *British Medical Journal* 322:95.

Terri L. Tanielian and Lisa H. Jaycox, eds. 2008. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: RAND Corporation.

Thoits, Peggy A. 1983. "Multiple Identities and Psychological Well-being: A Reformulation and Test of the Social Isolation Hypothesis." *American Sociological Review* 48(2):174-87.

Thoits, Peggy A. 1991. "On Merging Identity Theory and Stress Research." *Social Psychology Quarterly* 54(2):101-12.

Thoits, Peggy A. 1992. "Identity Structures and Psychological Well-being: Gender and Marital Status Comparisons." *Social Psychology Quarterly* 55(3):236-56.

Thoits, Peggy A. 1995. "Stress, Coping and Social Support Processes: Where Are We? What Next?" *Journal of Health and Social Behavior* (Extra Issue):53-79.

Thoits, Peggy A. 2011. "Self, Identity, Stress, and Mental Health." Pp. 357-78 in *Handbook of the Sociology of Mental Health*. 2nd ed, edited by C. S. Aneshensel, J. C. Phelan, and A. Bierman. New York: Springer.

Turner, R. Jay and William R. Avison. 1992. "Innovations in the Measurement of Life Stress: Crisis Theory and the Significance of Event Resolution." *Journal of Health and Social Behavior* 33:36-50.

Williams, Gareth. 1984. "The Genesis of Chronic Illness: Narrative Re-Construction." *Sociology of Health and Illness* 6(2):175-200.

Wright, Evan. 2008. *Generation Kill: Devil Dogs, Iceman, Captain America, and the New Face of American War*. New York: G.P. Putnam's Sons.

Young, Allan. 1995. *The Harmony of Illusions*. Princeton, NJ: Princeton University Press.