J Med Humanit (2018) 39:45–72
https://doi.org/10.1007/s10912-017-9484-y

Beyond Pathologizing Harm: Understanding PTSD in the Context of War Experience

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Published online: 16 November 2017

Abstract An alternative to objectifying approaches to understanding Post-traumatic Stress Disorder (PTSD) grounded in hermeneutic phenomenology is presented. Nurses who provided care for soldiers injured in the Iraq and Afghanistan wars, and sixty-seven wounded male servicemen in the rehabilitation phase of their recovery were interviewed. PTSD is the one major psychiatric diagnosis where social causation is established, yet PTSD is predominantly viewed in terms of the usual neuro-physiological causal models with traumatic social events viewed as pathogens with dose related effects. Biologic models of causation are applied reductively to both predisposing personal vulnerabilities and strengths that prevent PTSD,

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such as resiliency. However, framing PTSD as an objective disease state separates it from narrative historical details of the trauma. Personal stories and cultural meanings of the traumatic events are seen as epiphenomenal, unrelated to the understanding of, and ultimately, the therapeutic treatment of PTSD. Most wounded service members described classic symptoms of PTSD: flashbacks, insomnia, anxiety etc. All experienced disturbance in their sense of time and place. Rather than see the occurrence of these symptoms as decontextualized mechanistic reverberations of war, we consider how these symptoms meaningfully reflect actual war experiences and sense of displacement experienced by service members.

Keywords Post-traumatic stress disorder (PTSD) · Phenomenology · Social causation · Narrative · Trauma · Experience of war

Academic psychiatry tends to pick out Post-traumatic Stress Disorder (PTSD) as the one major diagnosis where social causation is established. Thus PTSD would seem to offer a special opportunity to employ a broader explanatory model beyond the current biological reductionism. However, through a sleight of hand, PTSD rapidly went from being a complex biopsychosocial syndrome requiring a new explanatory model to a disease state which is expected to be, ultimately, fully comprehensible through the usual causal models employed in neuroscience (Christova et al. 2015; Bennett, Hatton, and Lagopoulos 2015). It's not that PTSD's origins are seen as independent of social facts but rather that these facts are to be understood the way other causes of brain and bodily illness are understood—as objective, homogenized entities measurable as doses of exposure.

Isolating PTSD as an objective disease state essentially decontextualizes experience, taking the truth about PTSD to be independent of the narrative details. Personal stories and cultural meanings of the traumatic events are seen as epiphenomenal, not as essential for the understanding of, and ultimately, the therapeutic treatment of PTSD (Dreyfus 2015; Taylor 1985a; Taylor 1985b). In contrast, turning towards the humanities for alternative understandings and approaches to PTSD enables us to adhere closely to actual experiences across time and to commonalities in subjective experiences. This article presents an alternative to objectifying approaches to understanding PTSD that is grounded in philosophy, specifically hermeneutic phenomenology, an approach which offers a systematic way of talking about, understanding and researching first-person accounts of experience. This article focuses on the post-trauma experiences of wounded male servicemen (WSMs) in the Afghan and Iraq wars. There are of course many non-military sources of trauma, ranging from street violence to domestic violence including child abuse, to natural disasters. There are also veterans from other wars who may have returned to countries that welcome them for whom the post-war experience is very different. Our focus here is specifically on the PTSD experience of wounded service members returning to an indifferent United States from the wars in Iraq and Afghanistan. Since WSMs share a common language as well as overlapping war experiences, we can explore commonalities and contrasts in their narratives.

This article demonstrates the value of a broader explanatory model in psychiatry. The model is more comprehensive in that it shows how social and cultural meanings, or context, are constitutive of embodied experience. No one leaves war with the same sense of living in the world in which they entered combat. Soldiers experience radical changes in their sense of time, identity and place. War is world changing. Much of the discourse on the human experience of war focuses on the "inner wars" of the soldier, as if the soldiers' inner experience is radically separate from their immersion in the same real world that brought them to war and

to which they are returning. In this essay we will show how this inner/outer discourse is shaped by a pervasive philosophical assumption, since at least Descartes that our mental lives are disembodied and thus can be held private and separate from objective physical reality (Dreyfus and Taylor 2015). Rather our everyday experience makes it clear that to be human is to be embodied and immersed in the emotionally palpable environment that we live in and to feel "at home" in or alienated from. For the soldier this includes adapting to a constant surround of threat, taking immediate action when danger is imminent and experiencing intense emotional life-and-death relationships with others. These totalizing challenges radically alter, and out of necessity, create new, often unimagined, ways of being in the world. Understanding war experience as changes not *inside* the soldier but in what it's like for the soldier to be *in the world*, i.e., what matters to him, what he notices, is a phenomenological approach. This approach in which subjective experience and being in the world are embodied and always co-constructing each other offers a broader explanatory model for understanding PTSD (Wool 2012; Dreyfus 1991; Benner and Wrubel 1989; Merleau-Ponty [1962] 2012).

Anthropologist Allan Young (1997) noted that the efforts to consider PTSD a biological diagnosis increased with the publication of DSM-III in 1980, despite it having been considered to have social rather than biological origins. Subsequently, considerable effort has been devoted to establishing biological markers and "treatments and an entrenchment of PTSD's status as a single, coherent, verifiable, and discrete disorder" (Young 1997, 94-107). More recently, anthropologist Wool summarized the current approach to PTSD:

> PTSD is understood to be treatable, potentially preventable, and perhaps curable, all with recourse to increasingly biological and neurochemical means…. Treatment of PTSD is addressed to 'straightening out' the pathologically twisted temporality of memory that is seen to cause the unwanted re-experiencing of the traumatic event through intrusive thoughts and images. But treatment is also geared toward disciplining pathologized modes of perception and behavior such as avoiding or overreacting to stimuli associated with the traumatic event (such as crowds or loud noises) and under-reacting to 'normal' stimuli (displayed through flat affect or loss of interest in previously enjoyable activities). (Wool 2012,4-5)

The DSM-5 criteria for PTSD involve specific symptoms grouped by categories. For example, the category of intrusive symptoms includes:

1. recurrent, involuntary and intrusive memories
2. traumatic nightmares
3. dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness
4. intense or prolonged distress after exposure to traumatic reminders
5. marked physiological reactivity after exposure to trauma-related stimuli. (American Psychiatric Institute 2013)

There is value in having such symptom checklists for PTSD; they allow for self-report tools and interview measures. However, assessments based upon general, observable signs and symptoms, not first-hand "experience-near" accounts of actual events (Geertz 1977), are incomplete and can be misleading. Objectification, i.e., removing the person from the context, precludes studying the person's perceptions and behavior as *meaningful activity*. The objective PTSD symptom list "overlooks the full humanity of soldiering, and the healthy struggle in the

best soldier to remain alive to civilian sensibilities without losing the soldier's steel and resilience" (Sherman 2010, 92).

Our belief is that by considering how war radically reshapes the soldier's embodied sense of threat, skills and responses to what forever feels like a more dangerous world, we can shed new light on the post-war experience of soldiers and what is called PTSD. Our method is to adhere as closely as possible to the first-hand accounts of WSMs and the nurses who cared for them. By attending to deeply experiential themes like people's sense of temporality and place, and what it means to feel present *here* versus *there*, we are taking a phenomenological versus a diagnostic approach.

A phenomenological perspective on changes in the world of the soldier

From a phenomenological perspective (Merleau-Ponty [1962] 2012; Benner and Wrubel 1989; Dreyfus 1991), every soldier leaves war with shifts in embodied memory, identity, and sense of meaning that color understanding of his or her current lifeworld.[1] In contrast, a psychopathological view gives a workable self-understanding only to those soldiers who are able to accept the officially "confirmed" medical diagnosis of PTSD. As Wool (2012) and others point out (e.g., MacLeish 2013), a broader phenomenological view of how human beings both constitute and are constituted by their immersion in specific lifeworlds is useful for understanding the experiences of *all* returning soldiers, whether or not they become officially diagnosed with PTSD.

PTSD as a diagnosis can be a discussion stopper, both inside and outside healthcare circles. The "disorder" label PTSD often collapses into an absolutist discourse about whether or not the person has "it" or not. Those not given the formal diagnosis also experience significant challenges in adjusting to their post-war life that they may not feel free to share if they lack the diagnosis. Clinicians may focus only on the "short cut" list of decontextualized symptoms needed to be diagnosed with "it."

However, it is often stigmatizing to be diagnosed with PTSD. Allan Young notes that WSMs who have traumatic brain injury (TBI) insist that they should *not* be labeled as having PTSD, implying that TBI is "real" whereas PTSD is not (Young 1997; Sherman 2010). The Pentagon concluded that people suffering from PTSD should not be given the Purple Heart because PTSD "is a secondary effect caused by witnessing or experiencing a traumatic event," (Sherman 2010). So while a medical diagnosis usually legitimates an illness, for the WSMs, the PTSD diagnosis often stigmatizes and alienates them from their war experience. This kind of absolute diagnosis related to the human aftermath of war cuts off WSMs not only from civilians but even from each other, creating a schism between those with and without PTSD, despite the fact that they all share altered ways of being in the world including their basic sense of being in time and space.

Altered time sense is ubiquitous; in the wake of the war, the past bleeds into the present. War experience doesn't stay put as a discrete past. This is not surprising because temporality is always subjectively shaped by context; people do not experience time as a linear succession of moments (Merleau-Ponty [1962] 2012). Similarly, people experience an altered sense of space and place, the world of war creates new embodied knowledge, habits, and ways of dwelling in the world. Being *there* creates an incomplete ability to be *"here."* Trying to still be who one was "here" makes it difficult, and even dangerous, to be "there." Consider the challenge of trying to be armored psychologically, stoic and ready to die, and yet also to remain human and ethical.

In a study of the care and rehabilitation of soldiers, Kelley et al. (2015) found great confusion about the stigma and legitimacy of having continued stress triggered by past war

experiences. Veterans felt that others were puzzled and wondered: Why couldn't they just keep the past where it belonged?

Yet to be human is always to bring salient features of the past into present ways of being in the world. The way in which personal and cultural history directly shapes present embodiment is described by the sociologist Bourdieu through the concept of a skillful body *habitus* (Bourdieu 1977; Bourdieu 1990).[2] For example, if one is taught from birth to act subserviently and humbly, these culturally embedded social meanings will show up in the person's *habitus* or styles of comportment. The person whose spouse dies continues to dwell in a lifeworld where the partner's concerns still show up, in grocery shopping, cooking and in hundreds of old habits and skills that are triggered by daily life. The body learns to dwell in meanings and habits that are not easily banished. In war, the soldier learns a new level of hyper-vigilance not required in ordinary social spaces. And in strong traumatic experiences, such as war, one has limited power to constitute their environment. Danger lurks, comrades are killed, and one's own life is in danger most of the time.

Loss and harm from dwelling in a dangerous situation such as war can, as Merleau-Ponty describes, establish an altered temporality:

> Time and its passage does not carry away with it these impossible projects, it does not close up on traumatic experience; the subject remains open to the same impossible future, if not in his explicit thought, at any rate in his actual being. One present among all presents thus acquires an exceptional value; it displaces the others and deprives them of their value as authentic presents". (2012, 66)

This paper is built on the assumption that while human beings can try intellectually and mentally to compartmentalize past, present and future, they actually experience embodied and *perceptual* orientations and *sets to respond* (Merleau-Ponty 2012) from past experiences that guide their understanding of the present and project them into the future. The embodied WSM has experientially learned how to dwell in a world of war and carries embodied understandings and habits of thought and action into the present. The works of Merleau-Ponty (2012) and Hubert Dreyfus (1991) suggest that the lived mind-body-world relationships and potential real world interventions offer another level of interpretation and a new basis for understanding the human experience in the wake of a traumatic war. Studying PTSD as a cluster of isolatable objective symptoms or looking for an essential biological explanation (e.g., brain changes) does not substitute for the need to understand the historical, psychological and personal. We need both biological and phenomenological understanding since persons are both physical and narrative beings.

Methods[3]

This study examined the first-person experience-near accounts (Geertz 1977) of injury of wounded soldiers, from immediate in-field care, transport, acute and rehabilitation care in the military through early rehabilitation, through interviews with WSMs and Nurses. Once the study received human subject institutional review boards' (IRBs) approval from all facilities involved, volunteer participants were recruited through posted fliers or information presented locally in groups from nine Medical Treatment Facilities or Veterans Administration Medical Centers (VAMC) within the United States and Europe. Project managers screened all interested volunteers for meeting the eligibility criteria of having been deployed to any of the combat zones and being cognitively and

physically able to participate in the study. Screening was done through personal interview—no formal psychological screening was conducted—and with few exceptions, all volunteers met the criteria for participation. Given the sensitivity of the topic, our human subject protocol required that we accompany any interviewee directly to an appropriate mental health service should they become upset or anxious during the actual interview. This occurred twice, and both participants agreed to be accompanied to a mental health professional immediately. All participants signed written informed consents and were given printed referrals to available mental health services in case they were needed after the interview.

Based on years of successful experience with interpretive research (Benner 1984; Benner 1994; Chan et al. 2010), we chose small group interviews with interviewees who have experiences in common to create a communicative context in which participants' stories stimulate similar and contrasting experiences and memories among the group. Except for the few individuals who preferred being interviewed individually, we used primarily small group interviews of two to six people. WSMs and Nurses were interviewed separately, as the questions focused on each group's particular war experiences. The WSMs were asked for a personal account of their injury, transport, caregiving, and rehabilitation experiences. Nurses were asked to give first person narrative accounts of their war experiences and what it was like to care for soldiers along different points in the trajectory from field to hospital. They were also asked to recount stories of memorable patients, and many of these involved WSMs who had experienced traumatic experiences in war. Free expression of opinions and experiences were encouraged in these confidential interviews.

All interviews were recorded with permission, transcribed verbatim, and checked for accuracy. Two members of the research team experienced in interpretive phenomenology read a large sample of the Nurse and WSM transcripts and articulated twenty-five themes. The themes were selected to index faithfully the meanings and experiences of injuries and care of the WSMs and Nurses. The goal was to stay as close as possible to the participant's meanings and descriptions of events, feelings, concerns, and experiences.

The data were entered into the Atlas.ti Qualitative Analysis Software, version 7, for easy retrieval and comparisons of topics and themes between research team members. Interview *excerpts* coded for PTSD, PTSD combined with Traumatic Brain Injury (TBI), and common symptoms of PTSD— depression, flashbacks, suicide, anger, insomnia, nightmares, and conflict—that related to experiences in the field, in transport, in military hospitals, and in the VA Hospitals were retrieved. This article is based upon this interpretive analysis of these themes and excerpts related to PTSD.

Results

The sample included transcripts of interviews with a total of 401 nurses who provided care for soldiers, whether in the field of combat, in transport, in acute care in Landstuhl, Germany, and the United States or in the VAMCs. We interviewed sixty-seven soldiers who were in the rehabilitation phase of their recovery either in military care or the VAMCs. A joint civilian and military research team conducted the interviews in nine different locations. As the interviews took place between 2009 and 2011, sometimes months to two to three years after the traumatic experiences, the interviewees may have previously recounted their combat or caregiving experiences to others. All

the interviews occurred for the WSMs during a phase of their rehabilitation program either in the Military Health Care Sector or The Veteran's Administration Health Care System. All nurse interviews were currently employed by the Military Health Care Sector or the Veteran's Administration Health Care Sector. The following text describes soldier and nurse experiences of war and its aftermath based on the totality of interviews in the study.

Lifeworld: the powerful, formative experience of being 'there' and 'then'

The experience of combat epitomizes the power of being in a lifeworld that shapes not only one's daily actions but one's sense of ongoingness and expectations for the future. The experience is not just the blast of the injury. The loss is not just of body parts. It is a total experience—absolute brotherhood, heightened vigilance, disciplined bodies, strong emotions, military habitus, a machismo attitude, stoicism and detachment from feelings and bodily discomfort. The members of the units are so joined in their endeavor and danger and in their dependence on one another that they are like one body. They are intimately, deeply part of each other, and aggressively protect their "buddies," as they refer to each other.

In the Iraq and Afghanistan wars, injuries are usually sudden and surprising—e.g., involving an Improvised Explosive Device (IED) blast while walking on foot or riding in a vehicle—that result in poly trauma, usually including TBI. All WSMs are given life-saving treatment in the field and airlifted from the combat zone as soon as they are stable. The following story of being injured represents so many of the WSMs' stories:

> WSM: I remember everything clearly. I never lost consciousness. We were completing our first objective. And out of nowhere, I was helping out my fellow-soldier who was injured with me, we were a weapons squad, I was his team leader, and as soon as I helped him, two minutes later, while walking, the IED just dropped out of nowhere. I thought a mortar landed on us, because I felt the debris rush through my body. But at the same time, I closed my eyes, but I remember feeling everything—I was doing back flips, cartwheels. But I remember floating in the air. When I opened my eyes, I was at least fifty meters from where I was walking…I felt kind of dazed and confused, but I thought something had happened, but I didn't determine how bad it was. I tried to get back up, I couldn't. I tried to pick up the *equipment* but it was made into pieces, nothing. I just found myself looking up in the sky. It was very blue and—I don't know, it was just a beautiful day but …I was laughing, "If I was to die today, today would be a beautiful day to die." …And while they [the rescue helicopter] were trying to get to me and my friend, they were also taking fire. So it was kind of hectic at that moment. But within eight minutes later, I was out of there. Me and my friend were air-e-vacked [evacuated] to *a safer* zone. At that time we went to a Combat Support Hospital (CSH) regiment, and from there, I was there for two days, went straight to Landstuhl, Germany, and I was there for five days. Then they flew us back to the U.S.
> Interviewer (Int): You've been here [military acute and rehab center] three years… So were there sort of turning points, or hurdles, or challenges that stand out for you in that recovery?
> WSM: Since that day? It's a constant battle. I always can't get it out of my head. First thing when I wake up in the morning it's in my mind. Last thing before I go to sleep, it's

in my mind. Yesterday marked the third anniversary since my incident. So it's been three years ever since, and no matter what I try to do, it's always in my mind, stuck in my mind. It doesn't bother me as much. Sometimes it does but sometimes not, as I try to keep a positive attitude about it. I try to put the pieces together by talking to some of my comrades that were there at the time. And I'm always interested in knowing more details about it. Because the more details I put into perspective, the more I understand what really happened that day. And— it's always in my mind, like I said, it doesn't go away.
Int: Has there been anything along the way that you've found particularly helpful?
WSM: My faith is, but more being outspoken about it—to my wife—I tell her the stories—to doctors, psychiatrist, vet's centers, counselors. Right now I'm enrolled in College, so there's a lady that—she's a coordinator. And I also talk to her. So I find that talking about it and trying to get others to understand the situation of that particular day helps me, because it not only lets me get it out of my chest, but also try not to hide it.
Int: Right. To come to terms with it. What do you anticipate for the future?
WSM: Ever since *that day* [date of injury], for me, every day that I wake up is a gift. I feel that I wasn't supposed to have made it, but I did. And because I see it as a gift, I don't want to see it as a waste of attention. So I'm undecided of what I want in school. I just want to knock out my general courses. But I'm convinced that, maybe because of my faith, that I was allowed to continue living. There's something planned for me. I don't know yet, but I feel something is there.

This WSM illustrates two of the main issues in recovering from extreme trauma. The experience continues to spread out into the present. His sense of continuity and the way he experiences the present and how he projects his future are organized by the date of injury. He seeks to stitch his understanding of time and place together again through talking about it, owning up to what he feels, not hiding it—"getting it out of his chest." He tries to complete the story to better understand what happened. The moment of injury does not go away. He is reminded of the past from environmental cues [stated later in the interview], nightmares, flashbacks, and the residual shrapnel in his body. His sense of identity, safety and vulnerability has changed as a result of his war experience but so has his sense of place and future. In his memory he daily returns to the place and time of the injury: the *there* and the *then*. His war trauma has become world and self-defining. He experiences his survival as a gift, and even though the future remains vague, with his faith he believes that there is a reason he survived and that there must be something significant for him to do in the future.

On the one hand, the above paradigm case of being blown up in the air is a signature injury in the Iraq and Afghanistan wars. On the other hand, the soldier's quest to piece things together resonates with the stories of many Nazi Holocaust survivors (Benner, Roskies and Lazarus 1980) who wanted to hear about other's experiences, who wanted to return to the prison camps, see the "death showers" and stick their heads in the ovens to confirm for themselves that they had not made up their horrible and lasting memories. Like Holocaust survivors, veterans want confirmation that their flashbacks and residual vulnerability are not from inner demons but were caused by their real war experiences.

Being in active duty for one's country is already laden with meanings of patriotism, proving oneself and being brave on behalf of one's comrades. The soldiers we interviewed understood that their sacrifices were for their buddies and their country. We found little disenchantment,

even though WSMs were often angry and disappointed that they were so badly injured and could not return to fight with their buddies.

Being *there* not *here*: Disruptions of place and time

Most of the WSMs we interviewed had some confusion and alteration about their sense of place and time. For example, one WSM articulated clearly that those helping him with his TBI and PTSD had to understand both his medical condition and his shifts between immediate past war experience and the present.

> WSM: I came recently from war. I could be *here*, but I'm over *there*. I don't know if you understand—I'm still over *there* [in Afghanistan in war]… I'm still over *there*. And even with my condition, I'm still in defense mode. I'm always defensive. I can't find a way, how could I lower that defense mode? I can't, even if I go somewhere where there are a lot of people like a Mall, I can't. I have to leave.

His embodied habitus remains in the defensive mode. Crowded places prevent him from feeling safe and secure.

Nurses talked about learning how to approach and awaken soldiers who had just returned from combat and who still evidenced being in the place and time of war.

> Nurse: The first experience we had when they came initially, we didn't know how to treat them. A lot, especially the young ones, were so angry. We couldn't even ask them questions. What they had experienced was still so fresh. You come into their room with a little noise and it upsets them…They shout, "Close that window!" You want to help them but you don't know what to do….You dare not touch them when they are sleeping. They wake up angry.

In the soldier's words above, most were more likely to be *there* rather than *here*. Nurses learned that approaching or awakening a soldier soon after combat could be hazardous and developed particular protocols for waking up a WSM:

> Nurse: I knock on the door, if the door is closed, and then slowly open it, standing across the room and call their name to wake them up that way. I avoid, as much as possible, touching them. I just don't touch when they are waking up.

The next example reveals pervasive stigma associated with the formal diagnoses of PTSD reified in the nurses' account as "it." The WSM tried to avoid this all-or-none PTSD diagnosis because of the threat that it posed to his career. The nurse's parlance was more about identifying the soldier as having "it," PTSD, than the tragic experience described by the WSM.

> Nurse: He was 19 years old, and this was his first or second deployment, and he would do everything in his power not to go to sleep. He would drink these huge "Monsters" that are "Stimulant Containing Drinks." It's more than caffeine. So it's a stimulant, so it's definitely an energy drink, yeah. But he would drink three or four of those a day. And I was like, "why are you doing that?" But he was literally terrified to go to sleep. And when he would doze off for a little bit, he woke up screaming, and he would press the

call bell immediately, and we'd run in there, "What's wrong?" And he had a flashback. And I think obviously it's important for us to screen as best we can for PTSD, even if they're not here that long. And a lot of these guys are just resistant. They don't' want to admit they have it [PTSD].

The experience of being in war is still too fresh to consider giving the soldier a full-blown diagnosis of PTSD since few soldiers escape immediate flashbacks. Recently returning WSMs are confused about their sense of time and place, and most have nightmares and flashbacks. This above interview continues, and the nurse gets a more direct narrative understanding of the memories that this young WSM is coping with:

Int: [continued from interview above] Because they're worried it'll [diagnosis of PTSD] interfere with their career?
Nurse: Right. Or I feel like they're almost embarrassed to admit it. And if they know that other people have [it]. I just encouraged him, "Please go get help. You need this." And I even sat in there and talked to him a lot for a while, and some of the stories that he told me—the things that he had seen—and he was so young. I can't imagine.
Int: Give me examples of those stories.
Nurse: One of the stories he told—he was out in the battlefield and something happened to where somehow, there was an overturned vehicle, and it caught on fire and he watched his friend burn to death. They tried to get him out, and they couldn't. And just sitting there hearing this person screaming, "Help me, please help me!" And—I can't imagine being okay after that! And then seeing so many of his friends getting shot to death—he wanted to die. It was terrible.

Once one hears the actual story of loss and horror, the fear of flashbacks and nightmares and avoiding sleep makes sense. Yet the pressure to focus on whether or not the soldier fits the PTSD criteria trumps the understanding of the human aftermath of helplessly witnessing a friend's horrible death. PTSD becomes a handy shorthand that allows distancing and avoiding the actual horror of war experiences by the mental health professional.

WSMs and nurses alike described the helpful impact of working through, talking about their war experience with buddies who had similar experiences to them. Veterans felt lucky when they were located near their combat buddies because they understood what each other had gone through. It is the normalcy of discussing a real past experience that helps WSMs put their history and self-understanding together just as all humans are compelled to understand and integrate their life experiences.

WSM: One of the nurses was a sergeant and had been deployed a bunch of times, and the only way I actually stopped having nightmares was talking to that guy. Because the psychiatrist there was crazy, and I told him to never see me again. So I just started talking to that guy, and he was an awesome nurse, and the people there took care of my family really well.…

WSMs often experienced guilt, remorse and regret for the tragedies that they've experienced. It was not unusual for WSMs in this study to reject traditional psychiatric approaches to their treatment. In contrast, veterans have responded favorably to those psychiatrists who offer a more individualized, empathic approach, like Judith Broder, MD, who, along with psychologists and other therapists, founded "The Soldiers Project" to offer psychotherapy to address the "subjectivity" of veterans and their families in the wake of war.[4] Broder and her colleagues

describe how, through providing empathy and continuity of interest in the world of the veteran who is oscillating between *here* and "*there*, they can help veterans begin to tolerate and integrate what is otherwise intolerable.

Not being able to be *here*: Acute grief, general anxiety, inability to focus in the moment

Nurses returning to military hospitals after being deployed felt the impact of caring for patients who were similar to the wounded soldiers they had cared for in the field. The nurses could vividly imagine the wounded soldier's journey, now made more powerful with the reunions with the soldiers' loved ones:

> Nurse: The part that is the hardest is once you get back, if you're here at a Military Health Care Center, you're going to take care of those same patients. You're taking care of the same wounds that you took care of when you were deployed. We're still getting flights in two to three times a week. To work in an intensive care unit [ICU] and see those same patients—it's more emotional. I see my staff breaking down frequently, having to leave the bedsides. Then you see the husbands and the wives and the kids. Add that on top of it. It's often just too overwhelming at times. So I know I often have to bring in chaplains and we have to have sessions to help people to deal with those things. And of course I don't know the answer to it.

For these returning nurse soldiers, the past floods into memory and deepens their identification with the soldiers and their families. This combined with more time and social space in the present can make the grief feel overwhelming.

The disturbance of sense of time, place, and world for the WSM also manifests itself in general anxiety and the inability to focus in the moment. And some nurses never fully experience the present due to continued detachment and social isolation:

> Nurse Veteran: I have problems. I have a lot of stress. I have nightmares. I'm jittery. I have a hard time focusing. Which are all things that weren't there before. And I've noticed since being back, after working in the ER [Emergency Room] environment, I have a rough time in the ICU now. In the ER you can sit down for three hours. And ICU was just—it's such a focused thing... So when I came home, I had a hard time. But I think that there's other pieces, and I go to Mental Health and that's what they tell me.

This generalized anxiety left over from the dangerous environment and coping through detachment prevents the veteran nurses from fully experiencing the present. The past continues to solicit them and demand their attention. These nurses find it reassuring that others have similar anxieties when required to perform high demand situations that require one be fully present. The continued detachment also makes it difficult for them to notice and engage in challenges and meanings available in the present, such as family celebrations.

Embodied responses to environmental cues "here" as if they were *there*

For the soldiers, even more pervasive than full blown "flashbacks" were the frequently occurring misperceptions of environmental cues as if they had the same meanings as in the

battlefield. The WSM knew that they were "here" but kept responding in their habit body as if they were *there*:

> WSM: I remember when I come home from Iraq, and we got off the bus and everything, and I was just ready. I grabbed my bags and like, I kissed my wife and everything, grabbed my kid, and she already had my bags separated and we like threw them in the car and I was like, "Yeah, I'm going to drive." I was a driver in Iraq, and anything on the road, you memorize the roads real quick, and you see something out place—bam, immediately you stop. I didn't make it like maybe 200 yards, and I was like going all over the road, 'cause you own the road over *there*. You know, you run people off the road, whatever, it doesn't matter. And that's how it was when I come home forever, I couldn't drive for a long time. It's like I'd see someone in the road and like I'd freak out and take off. I'd run off the road. My wife was freaking out, but then, she just drove me everywhere until finally I got used to it.

Sitting in the car on the side where the explosion hit could make the soldier feel wary and unsafe. Sites of former danger and vulnerability get imprinted in the habit body. The particular circumstances and context of the injury spread out into lasting cues of danger long after the soldier has left the battlefield. Tacitly, the past spreads out before him as if it were the present:

> WSM:…And the PTSD aspect of things…, I cope with it now, like he said, every day, the numbness in my leg, the piece of shrapnel in my hand—I sit here and play with this thing all the time. I mean, it's never going to go away, so at least once every 60 seconds, I re-live it. ……I had a lot of PTSD issues. I couldn't drive at night half as well, 'cause I mean, highways in Iraq, they're four lanes, just like here. They're not quite as up to speed with ours. But it's the same scenario. And headlights, Hum-V headlights and Chevy truck headlights, they shine the same way on a road [as those in combat zone]. So whenever I was driving—I could drive a lot more, but when it comes to being in a passenger's seat, I couldn't do that for crap. Because I was in the passenger's seat in that [exploded] vehicle, and if any kind of debris was in the road that halfway resembled something like a box, or a round thing, it caused me to jump out of my skin.

Environmental triggers and hyper-vigilant responses to these triggers were universal in the soldier and nurse interviewees, regardless of whether or not they were diagnosed with PTSD:

> Nurse: Wounded warriors and PTSD—it isn't always patients in the bed. I have a buddy that's an RN, just got back from deployment a few months ago, and we were out popping fireworks or something, and he flipped out, jumped a fence and was low-crawling. Just like, "what are you doing?!" So anyway, I think we have a lot of issues on both sides of the bed—nurses and patients and doctors, I'm sure. I couldn't imagine what those combat medics see.

The person does not "intend" to over-react to loud noises or to the violent scenes in a war movie. What would have been an expert habit in the battlefield now backfires as the person misreads innocuous cues as dangerous. Bridging this gap requires reinterpretation at the habit level, like one does when experiencing different cultural and language contexts. It helps when clinicians recognize that the person is feeling so alienated and needs help with managing feelings of vulnerability and danger:

Nurse: I think I experienced this more in the pain management clinic than I have on the ward, but if we had a soldier that came in, and we had to do a procedure that required them to lie down flat, the table that has the hole for their face and everything, we would have a lot of responses from that. Some just couldn't do it. They would break out into a sweat. They'd start having an anxiety attack. A couple of them actually passed out on us, because for them, having that loss of control was just too much. They couldn't do it.
Int: It made them feel too vulnerable.
Nurse: Exactly. So we would have to anticipate that, and try to work around it. We'd always put oxygen on them, we would do the modified angle. If they couldn't put their face in the hole, we could somehow have their chin up, so that their head could be back a little bit. There were a lot of things that we had to do to accommodate their PTSD.

This kind of accommodation based on the WSMs' anxiety is respectful and goes a long way toward accepting and recognizing the everyday consequences of having gone to war. Where one sits in a car, how one manages to make sure they have a clear vision of their situation, as well as a clear exit strategy are strong embodied ways of being in the world.

We heard in the interviews how corporeal these memories are by their impact on the soldiers. Many soldiers found talking and telling their stories to be necessary for healing. As one said, "it helped me get it **out of** my chest" and "not to hide it." Another soldier described his corporeal reaction to PTSD therapy of Prolonged Exposure by a social worker that encouraged him to relive traumatic memories too early and too fast:

WSM: She was doing it kind of unsupervised within the first month I got back. And it really … kind of shut me down. *Like my body just kind of …fought back to feel anything and fought too hard*. And I didn't feel anything, and it made it pretty difficult for awhile. (italics added)

Timing is everything in recovery. If the soldier is still in the mode of stoic detachment and has only recently returned from war, he or she may not be able to tolerate re-immersion in the embodied feelings and stances of the war.

Flashbacks and nightmares: The intrusive return of being *there*

Stories of flashbacks and nightmares were detailed and vivid. The hospital room is transformed into the combat zone. Many WSMs tried to stay awake to protect themselves:

WSM: I can't sleep—I take pills for that. My first night in the hospital, I slept on the floor, and I'd wrap myself like a cocoon. Because everything was quiet, I didn't hear a person, I thought the enemy was outside, because everything was quiet. So I slept on the floor because that way, if the enemy was out there thinking that he would shoot me with an AK47, he could shoot, [but] he wouldn't get me. If they come slowly, walking on the floors or something, I would get them and shoot them. But I didn't have a rifle with me. So I said: "My rifle…I need my rifle!" So what I have to do, I have to fight one by one. I don't need a knife. I've got my strength, I could take them myself. See? I don't let the nurses come to my room. I tell them not to come to my room. And when I hear the door move, I would tell the nurse, "go away!" I flashed them with my flashlight, because I'm very attentive to anybody who comes into the room or touches that door. Why? Because

the door doesn't have a lock. So I don't sleep well. If I knew that the door had a lock, I could sleep better. But while the door doesn't have a lock, I don't sleep.

The WSM's sense of place and time are disturbed. Most of the WSMs acknowledged or described having nightmares and flashbacks.

WSM: And I get into [the hospital] and that's when …not having any sleep for a week and all these powerful drugs really kicked in. I started seeing people outside my window and they were just like, I was begging her [the nurse], 'take me out of the room, put me back in my old room, I don't care!' I was like trying to climb out of the bed and literally begging her. She came in there and she's like, 'there's no one here!' And she just left. And …I kept paging and begging them to take me out of there, but they just stopped responding to my pages. So I tried to climb out of my bed, and my machine started going off because I fell to the ground. That's what I had to do to finally get them to come in there. …climb out of my bed and fall down, just to set my machines off to finally get her to come in there. And then another nurse came in there with her and they were looking and saying, 'there's no one out there.' I was seeing it, because I ...had no sleep and all those drugs. To me it was real. I was experiencing this and I was terrified to be alone. And so she just left again, the bad nurse did, and the other nurse, who wasn't even my nurse, was asking me what was wrong. And I was like, "I'm seeing these people." So she got sheets and taped the sheets to the window so I wouldn't be able to see out the window anymore and it made it a lot—

I was still scared, but I wasn't terrified because I couldn't see them looking at me. And it made it a lot better, I was able to start cat napping again. And finally the next day apparently, I don't remember any of the next day, but I thought I had slept that whole day when I woke up that night. But apparently I hadn't been asleep at all, I had just been having a flashback. I thought I woke up in Afghanistan and I'd been captured by the Taliban, and I started trying to climb out of bed and my mom was sitting in there with me and she started freaking out, and tried to hold me down and call the nurse in there, and the nurses came in and they're trying to hold me down, and I was fighting them, so they called the male nurses in there and I grabbed one of them and I choked him with my arm, and I punched another one in the face, and they eventually had to restrain me and put me on 24-hour watch because I thought I had been captured by the Taliban. And then when they thought I had calmed down and they took the restraints off me. I was still asleep for all this, I thought, because I didn't come back into myself until 8 pm that night. Apparently, I started giving my mom hand signals telling her how we were going to escape and I thought we had escaped and I was giving her signals and stuff, how we should crawl through the desert and kinds of stuff. She was just watching me hoping I wouldn't freak out again, and I woke up at 8, and I was like, "okay, I'm into myself," because you know I was in the hospital, and I was like, "Man, that was a weird dream," and I said it was good to get to sleep that long, and she was like, "You weren't asleep. You were here and freaking out and punching people and stuff!"

This WSM imagines that he has been sleeping and dreaming during his semi wakeful state of the flashback. Many nurses commented that soldiers with multiple deployments had the most difficulty re-entering:

Nurse: He had been deployed eight times! He was a very big guy and was restless and combative. You were looking to make sure he didn't harm himself by pulling things out,

> and then he wakes up and he's just, eyes have the pinpoint pupils that you see sometimes with a lot of narcotics anesthesia. But what was significant, he kept asking for people and we kept orientating him to where he was. And he kept asking for, I think one was Eddie. He specifically kept listing people. So I got the idea he thinks he's back looking for his men. So we just try, kept trying to reassure him, not his pain, but he kept, I even got his wife to come back. Eventually, he recognized her, and then he still seemed cognizant, like he seemed alert and oriented, but then he really wasn't, because he was still asking about "those people," and she would have to go back and remind him, "No, remember this person's at home." He was in that [flashback] for almost an hour.

The patient is in a middle awareness with the past soliciting his concerns and fears and with a glimmer of awareness that he is here with his wife in the hospital. Many nurses described situations where the WSM did not seem to be situated in the present and became combative:

> Nurse: He backed himself in the corner, and when I came around the corner, he came out with his fists going at me. There had been no problems prior to this. So I'm backing up, he's saying: "I am going to hit you!" I'm saying: "Why? Don't hit me!" I was backing up and I was yelling for the other girls to call security. I knew he didn't know what he was doing. I knew in the morning he wouldn't remember… I could totally tell he was not himself. We were someplace else.

Nurses learned to limit stimulation and noises, particularly those that could reflect passing images. Often pulling the curtains and getting rid of disturbing visual cues was enough to help the WSM fall back asleep. The flashbacks of being in the battlefield were pervasive in our interviews with both nurses and WSMs' themselves describing behaviors of WSMs. A nurse describes caring for a patient coming out of a coma after a TBI:

> Nurse: So I was going to be the nurse one-to-one for that first day coming out of the ICU. He would look out the window and swear that there was a sniper standing there on the roof of our building, pointing a gun straight at him. And you could see—on top of the narcotics he would doze off to sleep—and you could see that his mind was just racing. He would be flinching and moving his arms like he was trying to defend himself in his sleep. And it was all you could do to kind of calm him, and it was a constant reminder, "I'm here, you're safe, we're going to take great care of you." And it was towards the end of my shift, that first day out of the ICU, his family was all there, and they were scared to see their loved one in this state. And towards the end of that day he kind of woke up and he said, "I want to hear the Marine Corps hymn"…So I pulled my iPhone out of my pocket and found a website that had a version of the Marine Corps hymn on it, and we just sat there and I just held that guy's hand, and we listened to that Marine Corps hymn over and over and over again. And he was clear for those couple hours that we just sat there at the end of that shift… And the next day he asked that the American flag be hung in front of his bed as well.

This is an example of a soldier using the Marine Corps anthem to situate and pull himself together as a marine. The hymn allows him to dwell in the meanings that make his soldier life possible (Winnicott [1971] 2005), allowing him to gather himself together after the flashbacks and the confusion. Through dwelling in the hymn he was able to move into the present and calm his anxious, hyper-active, vigilant body.

Imagining the comforts of home while being *there*

Thinking about home and even connecting to children and loved ones was a mixed blessing while in the combat zone. One deployed nurse soldier found that she could not see or talk to her children (by skype). It was just too painful. It pulled her home and disrupted her concentration and focus on being there in combat.

However, many nurses and WSMs used their imaginations about what would be comforting and possible at home to sustain them through the privations of war. Mundane everyday comforts such as real showers, food, and the comfort of loved ones loomed large in many of the soldiers' stories of being *there* with sustaining memories of the good things about being home:

> Nurse: We had a night with a group of guys who were getting rid of a lot of Iraqi munitions, and something went horribly wrong, and we had five senior enlisted killed and we had eight grievously injured. And I had one gentleman who was badly injured. And we were trying to point out the bright side; he was like two months from retirement… He was going home to his three-year-old daughter. And that's what he clung to, all night long. He was with me at night, and he couldn't sleep, and his head was shaved. Everybody's head was shaved out there because there was no way to bathe. We'd go weeks without bathing and he was cold, his head was cold. So I went and I got him [my] knit cap that I always put on when I would finally get a shower, put a cap on right away, because with the sand blowing around I would look like a sugar doll when I came out. So I gave him my knit cap which smelled like my shampoo and he refused to put it on. He held it, and he wouldn't let it go, because it reminded him of home, where he was going, his wife and his daughter. And just that smell. He wouldn't put it on. He shared it. He was passing it to the other guys. They all just wanted to smell this knit cap.

The smell of home, of a gentler more feminine world, was able to conjure up home and its comforts. Conjuring pleasant memories made many of the horrors and deprivations of war more bearable.

Being "here" while longing to be *there*

Many soldiers regretted not being able to go back and fight alongside their buddies. They wanted to stay with their unit and continue the fight until they all came home. Some soldiers stood out because they felt most fully alive in the combat arena where they could use their energy, focus, and skills to their maximum. Upon coming home they felt a letdown. In the following example, the nurse officer had run a combat Emergency Department with excellent medical officers he trusted and respected:

> Nurse: Coming back to here was different, was hard for me. If I could do that work [Emergency Department Head in Combat arena] and go home every day to my family, I'd do it every day. It's amazing. Yeah. You come back and still—anger. I got anger. I don't know why. It's there. I'm a lot more short-tempered than I was before I left. Stupid is stupid. When something's dumb, it's dumb. And that's the problem I'm having right now is, you see something, it's just not important. You find out when you're deployed what's important—clinically as well as in your profession—what's *really* important. We do a lot of stupid busy work for very little clinical impact. But the transition's hard. I

didn't think I was going to have as many issues as I do. I was surprised—my wife and I have had new conflicts—and she's told me, "You're acting differently now," and I didn't think I'd have that in my family life. I figured I'd have some professional issues. Just some overall just—melancholy—with not being there.

The challenges in his nursing leadership position here pale in comparison to what he was able to do in the war. He feels loss and sadness at not being fully engaged and focused, using all of his powers to do "good" work, saving lives. He misses being in a top performance mode. For the group of soldiers who longed to be 'there,' the present was less accessible and compelling. Compared to being in war, the present felt irritating, slow moving and required focus on mundane issues as if they were urgent.

Nurse One: …I guess all the situations that we had—when I came back here I thought everything was in slow motion. A lot of things were missing. The urgency was missing, the acuity was missing, the trust in the doctors with me when I can know, was missing. Over there it was easy to practice. But here, this dogma, the administration, was the harder part to readjust to, actually.
Nurse Two: And people are not as sick— once you come back—the people you see in the ER here are not as sick as they think they are.
Int: You never noticed that before.
Nurse Three: No. I was very patient. I don't know why. I tell myself that. (Cries) I've compared the soldiers I took care of, and I really felt sorry for them—to the patients I take care of now, that are demanding, that I know that they can get up and walk. They're alive. They haven't been shot at. It's just so minimal, you know.
Int: So that transition has been somewhat difficult, to make the switch.
Nurse Three: Yeah. I didn't want to say anything to anybody, but yes. I think I'm just sick and tired of patients that are healthy enough to fend for themselves and—
complaining. And here I am, taking care of young soldiers in Iraq without any eyesight, you know, now they're hard of hearing, their limbs are gone. And I know women can be cruel so—they will be teased. Even by adults. That really bothers me.

These nurses now find that what in the past had been meaningful nursing work seems trivial compared to the extreme injuries of war. Their judgments of ordinary sick folk are harsh, something they are unwilling to share with their colleagues since it is below their own professional expectations. These nurses' professional expectations have been radically reset. Their embodied style of comportment is geared for quick action and emergency situations, for patients whose needs are life and death and whose injuries are major. Their present work no longer calls them.

Most soldiers felt that the close-knit comradery they experienced in combat was unique and irreplaceable. The separation from their buddies is filled with concern and longing to be back with their military family. Nurses noted with amazement that the front line concern of WSM was often returning to fight with their unit:

Nurse: I think one thing that I've noticed with these active-duty guys that kind of blew my mind, is that—you would think that they would be a little bitter. About what got them into this situation, if they were deployed or if they were working. But the only thing that these guys talk about is getting back to their unit and getting back overseas. You would think—something that caused this person so much harm—that they wouldn't

want to go back and put themselves back in that position, but that's their main question, "When can I go back to my unit?" Even though—they can have an amputation or anything like that—it's like, "When can I get back? When can I get back to training? When can I go back to my unit?"

Int: Have you ever talked with them about why they have such a desire to return?

Nurse: Because they feel like it's that comradery, like—there's people there, that they were the closest—that's their family. A lot of these guys—it's sad, but patients come back and like, "who's going to be your non-medical attendant? Who's going to stay with you while you're here to get better?" And they have no one. They're a 20-year-old guy and they have no one to call and no one to help them. And so they see that as—*that* is their family, get me back there, because they feel like they can help. Like—since they are missing their buddies, something is missing from that unit that they could provide. And that sense of really true belonging.

There is no comparable feeling of support and comradery once the soldiers are separated from their unit. The usual affiliations in American life do not compare to that unity and trust formed in war.

For some, the loss and deprivation they had experienced and witnessed made returning to the comforts of American culture feel alienating rather than welcoming.

Nurse: I was very quiet too. I ate all the time. I was like, "food!" I was eating all the food I could eat. But I was very quiet too because I was just used to being quiet, I think at that point. Just going to the mall was a lot of observation. I wasn't saying anything; I was just observing people's way of life. I thought, "Wow, it's so weird that people are just shopping!" And it's the American way, there's nothing wrong with that, it's just our way. It's just so carefree and shopping, driving in our cars, or eating out, going out to dinner. I just thought that was so odd. I remember thinking, "Wow, people are just enjoying their life right now and there are people in Iraq right now getting blown up, or missing a limb, or having no eyesight, or any quality of life, and we're here in complete excess with food." I remember just thinking that this is so weird to me. I reverted back to my [American] ways…, but I just thought it was so odd that we had so much food and we couldn't do more over there.

This young nurse wants to go back to Iraq in some kind of humanitarian effort. Her sense of social justice had been challenged by the contrasts between America and Iraq in terms of poverty, food, and comfort. She initially was much more of an observer than participant in the American culture. Her war experience made her feel less at home here and challenged by the poverty and deprivations of a people amidst a war.

Stigma, social isolation and detachment "here" after being "there"

Nurse soldiers and WSMs alike told us about encountering group pressure not to complain or show up for treatment for PTSD:

WSM: The Army has a new policy where people had to be asked certain things at 60, 90, and I think 120 days. Our command handled it with, "Everybody show up in the auditorium! Anybody havin' bad dreams, need to see a psychiatrist? No? Okay, you're free to go. Sign this paper on the way out." (laughter)

We heard many such stories about how "military procedures" designed to identify soldiers who might need mental health services or who were having troubling symptoms were all but dismissed as less important than taking leave, getting back to work or so on. Stigma is a taken-for-granted hazard for asking for help or making a difficult transition from combat visible to the military.

In addition to external causes of isolation, many soldiers felt shame or guilt over violating internal norms and withdrew socially as a result. Survivor guilt and guilt over having killed or injured others in combat were kept private. Many soldiers talked about deliberately insulating themselves from too much stimulation and social demand when they returned home. Yet beyond any deliberate attempts at coping, many soldiers experience unwanted levels of emotional detachment, a battlefield necessity that now threatened personal relationships.

In the following example, detachment and isolation moved to dissociation that ended in an almost lethal suicidal attempt. This soldier suffered from guilt, feeling that his poor tactical decision caused the death of an officer:

> WSM: One of my biggest problems was that I pushed everybody away. I'm married with three kids, and—I mean, I pushed everybody away. And away it got to the point to where I didn't do anything with my kids because when I saw my two sons, I was seeing that kid throwing that grenade [that killed the officer]. I'd say: "Go, get outta here, go play somewhere else!" And it tore up my marriage big-time, to where—my wife's not even here with me. [He moves on to tell about his attempted suicide]
>
> …I couldn't remember anything that was going on. And I remember leaving work early, and I went to go and eat at local restaurant. And I ate the wings and everything, and I got in my car, and I took off, and—I have an iPod that plays my music. And there was a song that talks about—about Iraq and soldiers and everything, and—listening to the words of it started me thinking of everything that's going on back there. And apparently, I had gotten home, I had pulled my rosary off my rearview mirror, put it on me, sent a text to my family telling them that I was sorry, and then I took two weeks' worth of three different kinds of medication. My wife came home and found me on the couch, passed out. She couldn't lift me up or nothing. Next thing you know, I was waking up in the ER, they were asking me what was going on, what happened, and I couldn't tell them anything. So my wife— my doctor pulled my wife out to the side, and I could hear them talking, "what causes? What happened?" and my wife started telling him, "he goes through these feelings to where he starts thinking about everything that happens and he just can't remember anything, from Point A to Point B." And the doctor said, "Well, your husband's really lucky." He'd found the amount of medication that I took—I should have been gone. And to this day everybody still asks me, "Why did you try to do that?" I didn't *try* to do it, at least not in my sense, in my knowledge I didn't try and do it. But I mean, it's hard to sit and talk to people that say they understand. But unlike us three [in the interview], they've never been through it. You know. So how is it that you understand what I've been through if you've never been through it, if you never think about it? And to me, it's a lot easier to sit here and talk with guys that have done it, than it is to sit with a therapist and talk about it over and over and over. And I had talked to four different therapists before I got here [the rehabilitation facility]. And when I got here, it was like starting all over again. I had to tell them, from the time I hit ground to the time that I left, what was going on, and I told them I couldn't do it anymore. You know, 'cause it was always stuck in my head and I couldn't get it out. So they worked

> really well with me on not pushing me to talk about things. And they also worked really well on my treatment, the type of medication that I was on, they adjusted everything. And then the other thing is, they always have somebody calling you and checking up on you and making sure you're okay. And to have somebody [a Battalion Commander/ Counselor/Friend] that can explain everything to you and then still be your friend, and to be able to go out and have lunch with him, and not judge you for the things that have happened in the past because he's been through as well, it really helps a lot.

When we interviewed this young man, we were first puzzled about why he so identified with the other soldiers in rehabilitation; he had no visible wounds. But as he told his story, we could see how he imagined himself tarnished to an extent that his world had become un-livable. He was a proud and heroic soldier who now lived in a world where children could participate in killing and terror and where his own actions made him feel terrible guilt. His sense of being alone in his despair and his hopelessness about ever bridging his past with his present drove his dissociation and suicide attempt. Yet now, through finding comrades in rehab and feeling the empathy of his buddies, including the three who came with him to participate in the interview, he had found a way to travel with his personal experience from there to here and become available to the challenges and rewards of the present. For him, it was a long journey that required that others accompany him and hear his story.

Discussion

Understanding how formative war experiences are embodied in perceptions and body memories that cannot be shed like a military uniform helps us better understand how PTSD is a logical and not a pathological response to war. The DSM criteria for PTSD does not account for normal war experiences, yet hypervigilance, anxiety and sleepless nights are not uncommon in combat situations. Soldiers are trained to continue to function after experiencing terrifying events. They continue to show up for work. Military training is inculcated in them. It saves their lives. Their embodied responses to war are normal while they are deployed in a war zone. But these embodied responses to war become symptoms of PTSD when they return home: flashbacks, nightmares, insomnia; responding to present cues in terms of the reality of war; general anxiety, and detachment and numbness with family members.

The research and treatment of PTSD in returning war veterans is still not fully developed. Although there is a plethora of treatments currently used to treat the symptoms of PTSD (Cloitre et al. 2011), even the most optimistic studies show that about 30% of motivated participants were not helped (Monson et al. 2006), and most treatments have not yet been tested in samples of veterans of with PTSD (McIvaine 2012; Castro 2014; Wisco, Marx and Keane 2012). Evidence-based psychotherapies for PTSD include cognitive behavioral therapies, most prominently, Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) (Foa et al. 2009); a "national rollout" is currently disseminating these treatments throughout the Department of VA Healthcare System (Karlin et al. 2010). Meta-analyses have shown eye movement desensitization and reprocessing treatment (EMDR) to be effective in treating the core symptoms of PTSD, but some studies suggest that EMDR is less efficacious in military samples (Davidson and Parker 2001; Albright and Thyer 2010).

Colonel Carl Castro, director of the Military Operational Medicine Research Program, points to a fundamental limitation in the most recent DSM's definitions of PTSD, a critique

that implicitly points to the fundamental importance of the meaning and context of a trauma for prevention and treatment:

> "…the words "combat," "veteran," or "military" do not appear anywhere in the diagnostic description, not even in the section devoted to high risk occupations. The scientific evidence for lumping combat-related PTSD with PTSD related to other forms of trauma such as sexual or physical assaults, and survivors of natural disasters, such as hurricanes and floods, is questionable (see Adler and Castro 2013). Veterans of war often describe their combat and deployment experiences as the most exciting time of their life, something they would be willing do all over again. Such statements are made even by combat veterans who are suffering from PTSD! Yet, neither rape victims nor survivors of natural disasters ever describe their trauma experiences this way, although some individuals in disaster settings might find excitement in such situations that was unknown to them before. Most certainly we are describing two different populations." (Castro 2014, http://www.ejpt.net/index.php/ejpt/article/view/24713#CIT0079_24713, accessed July 5, 2015)

The importance of distinguishing the context and meaning of traumatic experiences supports the argument implicit in the phenomenological approach we have presented in this article, that embodied immersion in the war experience is fundamental to understanding, diagnosing, and treating what is considered to be PTSD. This represents an important corrective step in linking PTSD to the actual lived experiences of the servicemen.

This specific, combat-related approach to PTSD has been incorporated into a number of programs, such as the Battlemind Mental Health Training Program for returnees, which was shown to reduce significantly the mental health symptoms associated with PTSD, depression, and sleep in combat veterans returning from Afghanistan in series of group randomized trials (Adler, Bliese, McGurk, Hoge, and Castro 2009; Castro, Adler, McGurk and Bliese 2012). The military is now evaluating therapy in a compressed time frame, individual and group therapy sessions utilizing the natural bonding that exists among veterans.

Colonel Castro also thinks that significant life events, such as combat experience, can fundamentally alter personality (McIvaine 2012); it can change a person's priorities or have the person come to appreciate life more. Personality changes, Castro notes, have gone largely unrecognized. This is consistent with the authors' belief that the experiences at the base of PTSD diagnosis are not just symptoms that can be removed but changes in how the person experiences being in the world and life purpose. This also underscores that PTSD is not an objective disease that can be understood and treated isolated from the life experience of the WSM.

Research identifying experiential themes from the first person narratives of wounded servicemen can contribute to more effective treatment approaches. The moment of injury, whether caused by a brain jarring concussion, a body shredding impact, or by repeated emotional bombardment, is prominent in WSM's struggle to leave "there" and once again resume being "here." They are caught up in the struggle to piece together a specific event or narrative to make sense of the shattering losses that they've experienced and witnessed. The coping necessary in their postwar lifeworlds is diametrically opposed to the survival mechanisms necessary while at war. Hypervigilance that is no longer warranted becomes acute anxiety, paranoia or hostility. Appropriate caution in daily social interactions in a war zone becomes aloofness back at home. Many other embodied practices that helped with survival during war can be serious impediments to readjusting to civilian life.

Once the question is reduced to whether or not a traumatized person has PTSD or not in absolute diagnostic terms, the conversation shifts to objective evidence of pathology rather than coming to terms with the changes in the WSM's ways of being in the world after war. Broadening our understanding of PTSD to include formative world and temporality-altering outcomes for living after war will make visible the common experiences of re-entering one's life after war and the needs for support for all returning WSMs.

The logical connections between the symptoms of PTSD and the common experiences of disorientation in time and place provide an important clue to how to improve treatment for returning veterans. In addition to the existing model of psychiatric services targeted at managing discrete symptoms, what is needed is social scaffolding to provide continuity and agency in returning soldiers lives. To be specific, veterans need employment or other meaningful pursuits, continuity of healthcare, mental health services that not only better address their externalizing symptoms (for example, flashbacks) but also help them overcome emotional detachment and connect with their families. They need ways to stay close to other veterans, and they need ways to connect with civilians and the society that sent them to war. The evidence is that, while these needs are increasingly recognized (Adler et al. 2011; Adler et al. 2009), none of this is happening sufficiently at the present time (IOM 2014; Castro 2014).

Leaving military life due to permanent injuries required not only coming to terms with disabilities, but it also required learning new skills while struggling to leave behind skilled habits suited to combat. For many, and especially for the younger, less experienced WSMs, the move from the very communal structured military life with minimal autonomy to being an individual patient with one's own body to heal, and then to being a new citizen who must learn to navigate such things as renting an apartment and possibly finding a job or otherwise learning to be independent present the WMS with many new responsibilities.

Continuity of healthcare is desperately important from the time of a serious injury to instill a sense of trust sufficient for very vulnerable survivors to believe that they can go on. Yet such continuity is woefully absent (Kelley et al. 2015). WSMs report being asked repeatedly to retell their story to the ever-flowing stream of professionals in the highly specialized transport based care from the battlefield to home. For people whose narratives and sense of time and place are already disturbed, such discontinuous relationships can cause feelings of incoherence and unreality, and make it almost impossible to feel like an integrated self (Taylor 1985a; Taylor 1985b). This discontinuity and lack of one's story being known by caregivers caused time to be experienced more as an isolated series of nows rather than as having continuity from the past to the present to the future.

Russell B. Carr, a military psychiatrist, points to the disturbance in one's sense of time, including preoccupation with and re-experiencing of traumatic events (2011). Understanding the WSM's story is essential to attunement and to recovery. Time loses its coherent sense of continuity with past, present and future and becomes circular, cycling back to the time of the trauma experience (Stolorow 2007).

In the hospital setting, nurses could benefit from research and education on how to better deal with WSMs suffering from flashbacks. The WSMs are a new patient population with polytrauma and Traumatic Brain Injuries, in addition to the demands of transitioning physically, culturally and psychologically from the war. Flashbacks are common and have complex psychological and neurological determinants, and WSM's having flashbacks require calming at multiple levels. Nurses describe learning from experience how to better respond to the environmental cues that were triggering and enmeshed in the WSM's flashbacks. WSMs reported many incidents of nurses ignoring their requests when they were engaged in

flashbacks from the battlefield. Nurses reported that they intervened when some nurses abandoned patients during flashback because the nurse claimed that the WSMs' complaints were "unreal." As experience accrued, nurses increasingly attended to quieting the environment, such as covering windows, and TV screens, but still WSMs could encounter nurses who did not respond with direct actions to calm them while in a flashback. Some nurses were more apt to focus on symptoms of PTSD rather than the WSM's real and terrifying experience in the midst of flashback. Nurses who understood the flashback as a "real" experience conjured up from the recent combat, were more imaginative and responsive through listening and attending to the WSM's actual fears. On the more positive side, however, as was found in the study of the role of the Nurse Case Managers working with WSMs (see Kelley et al. 2015), case managers were sometimes able to function as keepers of the serviceman's story, as archaeologists of their disjointed histories. This story keeping provided understanding and continuity and was particularly useful as they traversed through the labyrinths of the military and veteran health systems.

In terms of mental health services, few WSMs found establishing an effective relationship with a psychological therapist easy and quick. Psychotherapists were more likely to focus on the symptoms of PTSD and less on the WSM's lived history that gave rise to their symptoms. WSMs are also shifted from one mental health professional or group to another depending on resources. Temporary relationships with different specialists and departments do not lend to a sense of continuity or of being known as a person and a WSM.

WSMs seeking to process and integrate their war experience with being home can and do benefit from psychotherapy that has continuity and can provide relationships of presence, being seen, recognized, and heard face to face. The founder of The Soldiers Project, Judith Broder,[5] describes how veterans at first do not trust that any civilian psychotherapist, no matter how expert, can really understand what they are going through. Yet when the relationship develops over time, the returning soldiers not only come to trust their civilian therapists but other civilians in their lives, showing greater emotional receptivity towards their spouses and children.

Broder and the other Soldier's Project therapists see the power of analytic empathic listening and continuity of care for helping veterans recover a sense of emotional aliveness. Military psychiatrist Carr found that he could not adequately help veterans suffering from PTSD until he adopted such an approach. He credits Robert Stolorow's account of trauma (2007) for shifting him away from a symptom-focused approach towards working to establish affective attunement with veterans:

> I was beginning to feel that their experience of the world and themselves had been shattered. They frequently did not seem to be in the same world as the rest of us, or at least me. I was recognizing the need for an approach that addresses shame and fosters a human relationship between patient and therapist, instead of fostering a distance based in alleged objectivity…. As Stolorow (2007) says, 'Pain is not pathology' (p. 10). Instead of the event itself, Stolorow focuses on the inability to bear the emotions related to the trauma as the source of pathology. This traumatic emotional experience must be processed with others in order to be integrated into one's experiential world. Affects, or emotions, occur between people, and disturbing emotional experiences require what Stolorow calls "attunement" from another person or group in order to bear and integrate them. This attunement consists of feeling understood, gotten. A sense of sharing the

> burden of overwhelming affect with someone else in a "holding context" gives these feelings a place to "live and become integrated." (2011, 473-475)

Staying connected to other veterans is another crucial way for WSMs to ground themselves and reduce symptoms of detachment and numbness. WSMs frequently spoke of the therapeutic effect of sharing their stories with others, most helpfully with others who had 'been there,' and secondly with close family members. The dispersal of unit members around the country is not in their favor, but one can imagine that new technology and social networks could facilitate keeping in touch with others who have experienced the war.

More broadly, as noted in earlier sections, the large societal gap between the military and civilian worlds exacerbates the disruptions of time and place characteristic of people with PTSD symptoms. Narrowing this societal-warrior gap could do much to bridge the gulf that returning warrior's experience.

The dramatic experiential distance between there and here is a specific social and historical characteristic of this war. The complete inability of many civilians to grasp the nature of the lifeworlds that these soldiers and nurses have experienced inevitably contributes to the difficulty of reentry for WSMs. The camaraderie they share with war buddies is healing, but for reintegration into society, they must also be able to have their experiences recognized, acknowledged and understood by other Americans who were not there. Here we mean a type of recognition much more substantial and real than the honors and official thanks they receive publically. Many WSMs do not feel like heroes (Finkler 2013), often carrying a burden of guilt for having been unable to save some of their fellow combatants, or having committed acts of killing that felt called for in the world of war but are abhorrent in the everyday civilian world and, at times, against the soldier's own code of honor. Those of us who have not been to war must be more interested to truly hear the stories of our soldiers, both out of moral responsibility but also to help diminish the tremendous gulf between there and here. Soldiers should not have to bear the moral burdens of the war alone, as they so frequently do today.

Veterans have different needs upon returning from war. But, as Edward Tick affirms, they all need the support and understanding of the leaders and citizens who sent them to war: Once the collective assumes responsibility for the war, the veteran's symptoms begin to disappear. The vet can stand with dignity, for even if the war was immoral or ill-advised, even if we did not win, he or she is still our honorable warrior returned from a war fought in our service. It is imperative for the health of our veterans that they experience other ordinary Americans and our leadership as walking with them and accepting accountability for our wars (Tick 2005, xx).

This is not just the responsibility of our leaders but of all of us ordinary citizens who do not go to war. How do we co-construct the distance that soldiers cannot bridge alone? What are the reasons that only some of us go there in the first place? What guilt do some of us feel about this, and how might that guilt lead us to compartmentalize soldiers' experiences into pathological entities?

An example of lessening the distance between *here* and *there* for WSMs is a "community reading" of the book, *What it Means to Go to War* (Marlantes 2011), that the city of Sacramento, California, organized. Many other books written about war experiences in Iraq and Afghanistan (for example, Klay 2014; MacLeish 2013; Tick 2005) could be used as a basis for book clubs or community-wide reading. Shared experience such as this can assist in closing the divide between the warrior and the ordinary citizen.

Conclusion

We call for no less than a societal shift in how we think about war and trauma, broadening the discussion well beyond "PTSD." Currently we are further isolating soldiers with trauma symptoms by treating them as if they are diseased persons suffering from a pathogen inside their brains. Instead, we need to cultivate genuine empathic curiosity about what most soldiers suffer from, which is an altered way of being in the world. This calls upon all of the caregivers, clinicians, employers and others who co-constitute their worlds to be open to the experiences returning soldiers cannot help but hold onto. Acknowledging the formative and transformative changes in embodied ways of being in the world that take place during war is essential for addressing the social and personal challenges soldiers face on returning.

The transition from a dangerous and hostile environment to home is not accomplished by a plane ride. Home is no longer the same home it was. The soldier is no longer the same person he or she was. Supporters of returning soldiers should not inadvertently collude with the military's demand for these WSM's to control emotions, suck it up, think of others first, be masculine, and keep terror or guilt inducing nightmares to oneself, contributing to the production and explosion of the diagnosis and phenomenon around PTSD.

Instead, all soldiers need support and understanding in bridging the gap from being *there* to once again being *here*. As we have seen, some nurses can be quite skilled in providing this sense of place and personal war history. More specific training is needed for nurses, other health and mental health care providers, family members and community members that teaches respect and understanding of what really happened, rather than focusing primarily on diagnostic evidence for presence or absence of PTSD. While communicating with war buddies certainly offers an opportunity of a shared world, ways to share experiences with other civilians are also needed.

Finally, then, the implications of a more experiential and contextualized understanding of war are myriad and profound. Instead of limiting our efforts to managing symptoms of PTSD, we can coach and support all soldiers in helping them move from *there* to *here*. Most soldiers need to lessen their war levels of detachment and stoicism in order to once again re-engage in their social and familial worlds. That can only happen if we, who did not go to war, can see how we share in the guilt and suffering of war, and how we too have had our lifeworlds changed by our shared responsibility for the Service Members' war experience. Soldiers can be helped by society making genuine efforts to fully engage them in the present and by helping professionals as well as community and family members sustaining genuine empathic curiosity about what they've been through. We need to change the current societal pressure pushing soldiers to keep their problems *there*, to truly include them in our mutual "here." We need to help returning soldiers find a present that is inclusive and rewarding. No amount of stress reduction and coping strategies that do not address the social meanings that have been dismantled or disrupted by war will help the WSMs rebuild a livable world where past, present and future have coherence and living on has value and social recognition.

Acknowledgements Acknowledgement to M. Epstein, *The Trauma of Everyday Life*. New York: The Penguin Press. 2013. Special Thanks and Tribute to all Service Members Who Participated in the Study.

Funding This study was funded by the TriService Nursing Research Program (TSNRP # N08-P11) Uniformed Services University of the Health Sciences; however, the information or content and

conclusions do not necessarily represent the official position or policy of, nor should any official endorsement be inferred by, the TriService Nursing Research Program, Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Compliance with Ethical Standards

Conflict of Interest Author A, Patricia Benner has no conflict of interest; Author B, Jodi Halpern has no conflict of interest; Author C. Deborah R. Gordon has no conflict of interest; Author D., Catherine Long Popell has no conflict of interest; Author E, Patricia Kelley has received research grants from TriService Nursing Research Program and has no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Human Subjects Research Approval was received by all participating institutions.

Informed Consent Informed consent was obtained from all individual participants included in the study

Endnotes

[1] We will use the words "lifeworld" and "world" interchangeably to indicate the person's experience of engaging in his or her everyday life, as constituted by identity, character, concerns, relationships, life history and more. It is the common human experience of dwelling in temporality, where past, present and future are inter-related, whether or not they are explicitly experienced by the person on not. For example the person may experience great continuity in their current lifeworld with their past, or they may seek to cut off, or numb themselves from an unwanted, traumatic, or difficult-to-integrate past.

[2] A similar embodied view is captured by Merleau-Ponty's "styles of comportment," with sedimented meanings embodied in our comportment (1962). Temporality and sense of place are both embodied and intertwined with the person's immersion in the world (Todes 2001; Merleau-Ponty 2012).

[3] For a fuller description of methods and sample see Kelley et al. (2015).

[4] Jodi Halpern conducted interviews with Broder and other Soldiers Project Therapists 2011-2013. See also: www.npr.org/templates/story/story.php?storyId=120278574.

[5] Broder, interview with Halpern, 2012.

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